

DEPARTMENT OF HEALTH CARE SERVICES

California Medicaid Management Information System (CA-MMIS)

NCPDP Standard Payer Sheet

Instructions Related to Transactions Based on NCPDP Version D.Ø

Version Number: 3.0
June 2012

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Revision History

Document Version Number	Revision Date	Revision Page Numbers	Reason for Revision
1. 0	December 2011	Full manual	Creation of Document
1.01	March 2012	Various	Edits per DHCS comments from FI Letter A-1283
1.02	March 2012	None	EPMO Review – no changes for template usage or grammar.
1.03	March 2012	All	QM Review – formatting changes
1.04	March 2012	58-102	Included Prior Authorization Transactions into the Payer Sheet
2. 0	April 2012	None	DHCS Approval
3. 0	June 2012	Various	Place of Service codes (307-C7) for Prior Authorization, Paid vs. Captured for response status, updated some code definitions, added certification dates and contact information

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1 NCPDP VERSION D.Ø CLAIM BILLING

***Start of Request Claim Billing (B1) Payer Sheet Template ***

Payer Name: California Medicaid (Medi-Cal)	Publication Date: December 2Ø11
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 61Ø442 For Claim Billing
Processor: ACS	PCN: N/A
Effective as of: December 2Ø11	NCPDP Telecommunication Standard Version/Release #: D.Ø
NCPDP Data Dictionary Version Date: July 2ØØ7	NCPDP External Code List Version Date: March 2Ø1Ø
Contact/Information Source: General Website – http://www.medi-cal.ca.gov/ HIPAA Section – http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_m.asp	
Certification Testing Window: Starts June 25, 2012	
Certification Contact Person: POS/Internet Helpdesk 1-8ØØ-541-5555	
Provider Relations Help Desk Information: 1-8ØØ-541-5555	
Other versions supported: NCPDP Telecommunication version 5.1	

OTHER TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B1	Drug Pricing Inquiry
B2	Claim Reversal
E1	Eligibility Verification

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When." The situation designated has qualifications for usage (Required if "x", not Required if "y").	Yes

Fields that are not used in the Request Claim Billing transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

CLAIM BILLING TRANSACTION

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

1.1 B1 - Claim Billing Request

Transaction Header Segment Question	Check	Claim Billing
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

	Transaction Header Segment			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN Number	61Ø442	M	
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø4-A4	Processor Control Number	Fill with Spaces	M	
1Ø9-A9	Transaction Count	1 through 4	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1= NPI	M	
2Ø1-B1	Service Provider ID		M	NPI of Submitting Pharmacy
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	PC/POS Version Number - 7 Bytes and Submitter ID - 3 Bytes	M	

Insurance Segment Question	Check	Claim Billing
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø2-C2	Cardholder Identification Number	Must be one of the following formats: CIN (nine characters) plus the BIC Issue Date (YYMMDD) MEDS ID (nine characters) plus the BIC Issue Date (YYMMDD) BID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters)	M	

Patient Segment Question	Check	Claim Billing
This Segment is always sent	X	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø4-C4	Date of Birth		R	
3Ø5-C5	Patient Gender Code		R	
311-CB	Patient Last Name		R	
3Ø7-C7	Place of Service		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility. <i>Payer Requirement:</i> Medi-Cal requires a valid POS as defined by ECL.

Claim Segment Question	Check	Claim Billing
This segment is always sent	X	
The payer supports partial fills		
The payer does not support partial fills	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/ Service Reference Number Qualifier	1- RX Billing	M	
4Ø2-D2	Prescription/ Service Reference Number		M	
436-E1	Product/Service ID Qualifier	Ø3 = National Drug Code NDC ØØ = Compound drug	M	
4Ø7-D7	Product/Service ID	For compound drugs this field should be Zero	M	
442-E7	Quantity Dispensed	For compound drug, this should be the amount of the entire multi-ingredient product.	R	
4Ø3-D3	Fill Number		R	
4Ø5-D5	Days Supply		R	
4Ø6-D6	Compound Code	1 = Not Compound 2 = Compound	R	
4Ø8-D8	Dispense as Written (DAW)/Product Selection Code		R	
414-DE	Date Prescription Written		R	
419-DJ	Prescription Origin Code		RW	<i>Imp Guide:</i> Required if necessary for plan benefit administration <i>Payer Requirement:</i> Medi-Cal requires this field

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
354-NX	Submission Clarification Code Count	Only 1 allowed	RW	<i>Imp Guide:</i> Required if Submission Clarification Code (42Ø-DK) is used <i>Payer Requirement:</i> Medi- cal only allows one repetition at this time. Please review available values in Submission Clarification Code (42Ø-DK)
42Ø-DK	Submission Clarification Code	7 = Medically Necessary (indicates that Code 1 Restrictions have been met) For Compounds Only: 8 = Process Compound for Approved Ingredients 99 = Other (indicates Code 1 Restrictions have been met and Process Compound for Approved Ingredients)	RW	<i>Imp Guide:</i> Required if clarification is needed and value submitted is greater than zero (Ø) <i>Payer Requirement:</i> For compounds, do not send multiple repetitions; use code 99 to include both Medically Necessary and Process for Approved Ingredient clarifications

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø8-C8	Other Coverage Code	<p>1 = No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.</p> <p>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.</p> <p>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</p> <p>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.</p>	RW	<p><i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers</p> <p><i>Payer Requirement:</i> Required if beneficiary has other coverage</p>

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
461-EU	Prior Authorization Type Code	1 = Prior Authorization 8 = Payer Defined Exemption (used in conjunction with the Discharge Date for compound drug transactions)	RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility</p> <p><i>Payer Requirement:</i> Required when the claim requires Prior Authorization/Approval, Medi-Cal will process values 1 and 8 in the system</p> <p>Note: The Prior Authorization Number (field 462-EV) will be mapped as a TAR number if the Prior Authorization Type Code is one of the above values, except for a value of 8. If 8 is submitted, the Prior Authorization Number (Field 462-EV) will be considered as the Discharge Date (used for compounds only).</p>
462-EV	Prior Authorization Number Submitted		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility</p> <p><i>Payer Requirement:</i> Required when 461-EU is submitted with code value 1 and 8. Field 462-EV will be mapped as TAR number except for code value 8 when submitted which will be the Discharge Date (used for compound drugs only).</p>
995-E2	Route of Administration		RW	<p><i>Imp Guide:</i> Required if specified in trading partner agreement</p> <p><i>Payer Requirement:</i> Required when billing compound drugs</p>

Pricing Segment Question	Check	Claim Billing
This Segment is always sent	X	

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	Ingredient Cost Submitted		R	
412-DC	Dispensing Fee Submitted		RW	<p><i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation Zero (Ø) is a valid value</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
433-DX	Patient Paid Amount		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing or patient financial responsibility</p> <p><i>Payer Requirement:</i> Required when Medi-Cal share of cost is collected by Pharmacy</p>
438-E3	Incentive Amount Submitted		RW	<p><i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (430-DU) calculation Zero (Ø) is a valid value</p> <p><i>Payer Requirement:</i> Required for Sterility Testing Fee (Compounds only)</p>
430-DU	Gross Amount Due		R	Total price claimed from all sources. Include Compounding and Professional fees for compound drugs in the Gross Amount Due field.

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
423-DN	Basis of Cost Determination	Submit Ø8 for 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	R	

Prescriber Segment Question	Check	Claim Billing
This segment is always sent	X	
This segment is situational		

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	Prescriber ID Qualifier	Ø1= NPI	RW	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used <i>Payer Requirement:</i> Medi-Cal requires this field
411-DB	Prescriber ID		RW	<i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement:</i> Medi-Cal requires NPI of the prescriber

COB/Other Payer Segment Question	Check	Claim Billing
This segment is always sent		
This segment is situational	X	Required for secondary, tertiary, etc, claims
Scenario 1 – Other Payer Amount Paid Repetition Only	X	
Scenario 2 – Other Payer Patient Responsibility Amount Repetitions and Benefit Stage Repetition Only		
Scenario 3 – Other Payer Amount Paid, Other Payer Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

	COB/OP Segment Identification (111-AM) = "Ø5"			Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	Coordination of Benefits/Other Payments Count		M	
338-5C	Other Payer Coverage Type		M	
341-HB	Other Payer Amount Paid Count	Maximum count of 9	RW	<p><i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
342-HC	Other Payer Amount Paid Qualifier		RW	<p><i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

	COB/OP Segment Identification (111-AM) = "Ø5"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
431-DV	Other Payer Amount Paid		RW	<p><i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Zero (Ø) is a valid value. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted.</p> <p><i>Payer Requirement:</i> Field should contain the individual amount of all reimbursement received from all other coverage payers</p> <p>Occurrence depending on count in field 341-HB</p>

DUR/PPS Segment Question	Check	Claim Billing
This segment is always sent		
This segment is situational	X	Required if a DUR Alert Cancellation Requested or send if there is DUR/PPS Information to be sent.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
473-7E	DUR/PPS Code Counter	Maximum count of 1	RW	<i>Imp Guide:</i> Required if DUR Segment is used <i>Payer Requirement:</i> Same as Imp Guide
439-E4	Reason for Service Code	AT = Additive Toxicity DA = Drug-Allergy Conflict DD = Drug-Drug Interaction ER = Overutilization (Early Refill) HD = High Dose ID = Ingredient Duplication LD = Low Dose LR = Underutilization - Late Refill MC = Drug-Disease Conflict (Reported) MX = Incorrect Duration of Therapy PA= Drug-Age Alert (Pediatric or Geriatric) PG = Drug pregnancy conflict SX = Drug-Gender Conflict TD = Therapeutic Duplication	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement:</i> For DUR Cancellation Request, the Submitter transmits the value received from host system
44Ø-E5	Professional Service Code	MØ = Prescriber PØ = Patient RØ = Another Source	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement:</i> Same as Imp Guide

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
441-E6	Result of Service Code	1A = Filled, false positive 1B = Filled prescription as is 1C= Filled with different dose 1D = Filled with different direction 1E = Filled with different drug 1F = Filled with different quantity 1G= Filled with Prescriber Approval 2A = Prescription not filled 2B = Prescription not filled directions clarified	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement:</i> For DUR Cancellation Request one of the following values 2A or 2B must be present

Compound Segment Question	Check	Claim Billing
This segment is always sent		
This segment is situational	X	Required for submitting compound drug

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
45Ø-EF	Compound Dosage Form Description Code		M	
451-EG	Compound Dispensing Unit Form Indicator		M	
447-EC	Compound Ingredient Component Count	Medi-Cal supports up to 24 compound product IDs and 1 for the container count (25 Product IDs if a container count is included)	M	

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
488-RE	Compound Product ID Qualifier	Ø3 = National Drug Code (NDC) 99 = Other (Container Count) Must be accompanied with 9999999997 in field 489-TE When a product ID of all 9999999997 is submitted then the quantity in field 448-ED will be considered the Container Count	M	
489-TE	Compound Product ID	NDC Number When specifying the number of containers as an ingredient the NDC should be equal to 9999999997	M	
448-ED	Compound Ingredient Quantity		M	<i>Payer Requirement:</i> Used to indicate number of containers for compound drugs when Compound Product ID is 9999999997 and Compound Product ID Qualifier is 99 Maximum allowed is 999 containers
449-EE	Compound Ingredient Drug Cost		RW	<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed <i>Payer Requirement:</i> Required for each ingredient

Compound Segment Segment Identification (111-AM) = "1Ø"				Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
49Ø-UE	Compound Ingredient Basis Of Cost Determination	Submit Ø8 for Disproportionate Share/Public Health Service	RW	<p><i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Clinical Segment Question	Check	Claim Billing
This segment is always sent		
This segment is situational	X	Please see Pharmacy Provider Manual for diagnosis code submission requirements for claim payment

Clinical Segment Segment Identification (111-AM) = "13"				Claim Billing
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	Diagnosis Code Count	Medi-Cal supports one or two diagnosis codes	RW	<p><i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
492-WE	Diagnosis Code Qualifier	Ø1= International Classification of Diseases (ICD-9-CM)	RW	<p><i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

424-DO	Diagnosis Code		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
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*****End of Request Claim Billing (B1) Payer Sheet Template*****

1.2 B1 - Claim Billing Response

1.2.1 Accepted/Paid or Duplicate of Paid

****Start of Response Claim Billing (B1) Payer Sheet Template****

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)	Date: December 2011	
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 610442 For Claim Billing	PCN: N/A

The following lists the segments and fields in a Response Claim Billing Transaction (Paid or Duplicate of Paid) for *NCPDP Telecommunication Standard Implementation Guide Version D.0*

Response Transaction Header Segment Question	Check	Claim Billing Accepted/Paid or Dup of Paid
This segment is always sent	X	

	Response Transaction Header Segment			Claim Billing Accepted/Paid or Dup of Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Claim Billing Accepted/Paid or Dup of Paid
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Claim Billing Accepted/Paid or Dup of Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Patient Segment Question	Check	Claim Billing Accepted/Paid or Dup of Paid
This segment is always sent		
This segment is situational	X	Required when Beneficiary information is found

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing Accepted/Paid or Dup of Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
31Ø-CA	Patient First Name		RW	<i>Imp Guide:</i> Required if known <i>Payer Requirement:</i> Same as Imp Guide
311-CB	Patient Last Name		RW	<i>Imp Guide:</i> Required if known <i>Payer Requirement:</i> Submitted last name will not be sent when Beneficiary not found

Response Status Segment Question	Check	Claim Billing Accepted/Paid or Dup of Paid
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Claim Billing Accepted/Paid or Dup of Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	P = Paid D = Duplicate of Paid	M	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> Contains Medi-Cal Cutback Code, if present.
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used and another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Question	Check	Claim Billing Accepted/Paid or Dup of Paid
This segment is always sent	X	

	Response Claim Segment Identification (111-AM) = "22"			Claim Billing Accepted/Paid or Dup of Paid
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number	Same value as in request	M	

Response Pricing Segment Question	Check	Claim Billing Accepted/Paid or Dup of Paid
This segment is always sent	X	

	Response Pricing Segment Identification (111-AM) = "23"			Claim Billing Accepted/Paid or Dup of Paid
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	Patient Pay Amount		R	
506-F6	Ingredient Cost Paid		R	
509-F9	Total Amount Paid		R	

1.2.2 Accepted/Rejected

Response Transaction Header Segment Question	Check	Claim Billing Accepted/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Claim Billing Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	Response Transaction Header Segment			Claim Billing Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	A = Accepted	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request	M	
2Ø1-B1	Service Provider ID	Same value as in request	M	
4Ø1-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Claim Billing/ Accepted/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Claim Billing Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø4-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Patient Segment Question	Check	Claim Billing Accepted/Rejected
This segment is always sent		
This segment is situational	X	Required when Beneficiary information found

	Patient Segment Identification (111-AM) = "Ø1"			Claim Billing Accepted/Rejected
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
31Ø-CA	Patient First Name		RW	<i>Imp Guide:</i> Required if known <i>Payer Requirement:</i> Same as Imp Guide
311-CB	Patient Last Name		RW	<i>Imp Guide:</i> Required if known <i>Payer Requirement:</i> Submitted last name will not be sent when Beneficiary not found

Response Status Segment Question	Check	Claim Billing Accepted/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Claim Billing Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Rejected	M	
51Ø-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
13Ø-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing Accepted/Rejected
526-FQ	Additional Message Information		RW	<p><i>Imp Guide:</i> Required when additional text is needed for clarification or detail</p> <p><i>Payer Requirement:</i> Free form messages contains text message area, denial code(s) and eligibility-related Information</p>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
549-7F	Help Desk Phone Number Qualifier		RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
55Ø-8F	Help Desk Phone Number		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Response Claim Segment Question	Check	Claim Billing Accepted/Rejected
This segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number	Same value as in request	M	

Response DUR/PPS Segment Question	Check	Claim Billing Accepted/Rejected
This segment is always sent		
This segment is situational	X	Required if DUR information needs to be sent

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			Claim Billing Accepted/ Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
567-J6	DUR/PPS Response Code Counter	Maximum count of 1	RW	<i>Imp Guide:</i> Required if Reason For Service Code (439-E4) is used <i>Payer Requirement:</i> Same as Imp Guide
439-E4	Reason for Service Code	AT = Additive Toxicity DA = Drug-Allergy Conflict DD = Drug-Drug Interaction ER = Overutilization (Early Refill) HD = High Dose ID = Ingredient Duplication LD = Low Dose MC = Drug-Disease Conflict (Reported) LR = Underutilization - Late Refill MX = Incorrect Duration of Therapy PA = Drug-Age Alert (Pediatric or Geriatric) PG = Drug pregnancy conflict SX = Drug-Gender Conflict TD =Therapeutic Duplication	RW	<i>Imp Guide:</i> Required if utilization conflict is detected <i>Payer Requirement:</i> Same as Imp Guide
528-FS	Clinical Significance Code	Blank = Not Specified 1 = Major 2 = Moderate 3 = Minor	RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict <i>Payer Requirement:</i> Same as Imp Guide
529-FT	Other Pharmacy Indicator		RW	<i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict <i>Payer Requirement:</i> Same as Imp Guide

	Response DUR/PPS Segment Identification (111-AM) = "24"			Claim Billing Accepted/ Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
530-FU	Previous Date of Fill		RW	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
531-FV	Quantity of Previous Fill		RW	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (530-FU) is used.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
532-FW	Database Indicator		RW	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
533-FX	Other Prescriber Indicator		RW	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
544-FY	DUR Free Text Message		RW	<p><i>Imp Guide:</i> Required if needed to supply additional information for the utilization conflict</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

1.2.3 Rejected/Rejected

Response Transaction Header Segment Question	Check	Claim Billing Rejected/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Claim Billing Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Claim Billing Rejected/Rejected
This segment is always used		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Claim Billing Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Claim Billing Rejected/Rejected
This segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> Free form messages contains text message area, denial code(s) and eligibility-related Information

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
549-7F	Help Desk Phone Number Qualifier		RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
55Ø-8F	Help Desk Phone Number		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

*****End of Response Claim Billing (B1) Payer Sheet Template*****

2 NCPDP VERSION D.Ø CLAIM REVERSAL

2.1 B2 - Claim Billing Reversal Request

Start of Request Claim Billing Reversal (B2) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)		Date: December 2Ø11
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 61Ø442 For Claim Billing Reversal	PCN: N/A

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When." The situation designated has qualifications for usage (Required if "x", not Required if "y").	Yes

Fields that are not used in the Request Claim Billing Reversal transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

Question	Answer
What is your reversal window? (If a transaction is billed today, what is timeframe for reversal to be submitted?)	18 Months

CLAIM BILLING REVERSAL

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

Transaction Header Segment Question	Check	Claim Reversal
This segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is not used		

	Transaction Header Segment			Claim Reversal
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	Bin Number	610442	M	
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B2	M	
104-A4	Processor Control Number	Fill with Spaces	M	
109-A9	Transaction Count	1	M	
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID		M	NPI of Submitting Pharmacy
401-D1	Date of Service		M	
110-AK	Software Vendor/Certification ID	PC/POS Version Number - 7 Bytes and Submitter ID - 3 Bytes	M	

Insurance Segment Question	Check	Claim Reversal
This segment is always sent	X	
This segment is situational		

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Reversal
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø2-C2	Cardholder Identification Number	Must be one of the following formats: CIN (nine characters) plus the BIC Issue Date (YYMMDD) MEDS ID (nine characters) plus the BIC Issue Date (YYMMDD) BID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters)	M	

Claim Segment Question	Check	Claim Reversal
This segment is always sent	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Reversal
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/Service Reference Number Qualifier	1 = RX Billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	Ø3 = National Drug Code NDC ØØ = Compound drug	M	
4Ø7-D7	Product/Service ID	For compound drugs this field should be Zero	M	

*****End of Request Claim Billing Reversal (B2) Payer Sheet Template*****

2.2 B2 - Claim Reversal Response

2.2.1 Accepted/Approved

Start of Response Claim Reversal (B2) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)	Date: December 2011	
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 610442 For Claim Billing Reversal	PCN: N/A

The following lists the segments and fields in a Response Claim Reversal Transaction (Accepted/Approved) for NCPDP Telecommunication Standard Implementation Guide Version D.0.

Response Transaction Header Segment Question	Check	Claim Reversal Accepted/Approved
This segment is always sent	X	

Field #	Response Transaction Header Segment	Value	Payer Usage	Claim Reversal Accepted/Approved
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Claim Reversal Accepted/Approved
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Claim Reversal Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Claim Reversal Accepted/Approved
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Claim Reversal Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	A = Approved	M	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Response Claim Segment Question	Check	Claim Reversal Accepted/Approved
This segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription Service Reference Number	Same value as in request	M	

2.2.2 Accepted/Rejected

Response Transaction Header Segment Question	Check	Claim Reversal Accepted/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	B2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Claim Reversal Accepted/Rejected
The segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Claim Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Claim Reversal Accepted/Rejected
This segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
51Ø-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
13Ø-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
549-7F	Help Desk Phone Number Qualifier		RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
55Ø-8F	Help Desk Phone Number		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Response Claim Segment Question	Check	Claim Reversal Accepted/Rejected
This segment is always sent	X	

	Response Claim Segment Identification (111-AM) = "22"			Claim Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription Service Reference Number	Same value as in request	M	

2.2.3 Rejected/Rejected

Response Transaction Header Segment Question	Check	Claim Reversal Rejected/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	B2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Claim Reversal Rejected/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Claim Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Claim Reversal Rejected/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Claim Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Identification (111-AM) = "21"			Claim Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Identification (111-AM) = "21"			Claim Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

*****End of Response Claim Reversal (B2) Payer Sheet Template*****

3 NCPDP VERSION D.Ø DRUG PRICING INQUIRY

3.1 B1 - Drug Pricing Inquiry Request

***Start of Request Drug Pricing Inquiry (B1) Payer Sheet Template ***

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)	Publication Date: December 2Ø11
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: ØØ8589 For Price Inquiry
Processor: ACS	PCN: N/A
Effective as of: December 2Ø11	NCPDP Telecommunication Standard Version/Release #: D.Ø
NCPDP Data Dictionary Version Date: July 2ØØ7	NCPDP External Code List Version Date: March 2Ø1Ø
Contact/Information Source: General Website - http://www.medi-cal.ca.gov/ HIPAA Section- http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_m.asp	
Certification Testing Window: Starts June 25, 2012	
Certification Contact Person: POS/Internet Helpdesk 1-8ØØ-541-5555	
Provider Relations Help Desk Information: 1-8ØØ-541-5555	
Other versions supported: NCPDP Telecommunication version 5.1	

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When." The situation designated has qualifications for usage (Required if "x", not Required if "y").	Yes

Fields that are not used in the Request Drug Pricing Inquiry transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.

DRUG PRICING INQUIRY TRANSACTION

The following lists the segments and fields in a Drug Pricing Inquiry Transaction for *NCPDP Telecommunication Standard Implementation Guide Version D.Ø*.

Drug Pricing Inquiry Clarification

The drug pricing inquiry in Medi-Cal was intended to facilitate cash pricing when filling a prescription for a Medicare patient. Under California law (SB 393), pharmacies may charge a Medicare patient no more than Medi-Cal's payment, plus a small (15 cent) processing fee when the patient must pay cash. In the pricing

inquiry, Medi-Cal will return the allowable payment (ingredient cost + dispensing fee), plus the 15 cent processing fee.

Transaction Header Segment Question	Check	Drug Pricing Inquiry
This segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

	Transaction Header Segment			Drug Pricing Inquiry
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN Number	ØØ8589	M	
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø4-A4	Processor Control Number	Fill with Spaces	M	
1Ø9-A9	Transaction Count	1 through 4	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1 = NPI	M	
2Ø1-B1	Service Provider ID		M	NPI of Submitting Pharmacy
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	PC/POS Version Number - 7 Bytes and Submitter ID - 3 Bytes	M	

Insurance Segment Question	Check	Drug Pricing Inquiry
This segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Drug Pricing Inquiry
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	Cardholder Identification Number	999999999	M	

Claim Segment Question	Check	Drug Pricing Inquiry
This segment is always sent	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Drug Pricing Inquiry
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/ Service Reference Number Qualifier	1 = RX Billing	M	
4Ø2-D2	Prescription/ Service Reference Number		M	
436-E1	Product/Service ID Qualifier	Ø3 = National Drug Code NDC ØØ = Compound drug	M	
4Ø7-D7	Product/Service ID	For compound drugs this field should be Zero	M	
442-E7	Quantity Dispensed	For compound drug, this should be the amount of the entire multi-ingredient product	R	
4Ø3-D3	Fill Number		R	

Pricing Segment Question	Check	Drug Pricing Inquiry
This segment is always sent	X	

	Pricing Segment Segment Identification (111-AM) = "11"			Drug Pricing Inquiry
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
4Ø9-D9	Ingredient Cost Submitted		R	
43Ø-DU	Gross Amount Due		R	Total price claimed from all sources. Include Compounding and Professional fees for compound drugs in the Gross Amount Due field.

*****End of Request Drug Pricing Inquiry (B1) Payer Sheet Template*****

3.2 B1 – Drug Pricing Inquiry Response

3.2.1 Accepted/Captured

Start of Response Drug Pricing Inquiry (B1) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)	Date: December 2011	
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 008589 For Price Inquiry	PCN: N/A

The following lists the segments and fields in a Response Drug Pricing Inquiry Transaction (Accepted/Captured) for *NCPDP Telecommunication Standard Implementation Guide Version D.0*.

Response Transaction Header Segment Question	Check	Drug Pricing Inquiry Accepted/Paid
This segment is always sent	X	

	Response Transaction Header Segment	Value	Payer Usage	Drug Pricing Inquiry Accepted/Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Drug Pricing Inquiry Accepted/Paid
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Segment Identification (111-AM) = "2Ø"			Drug Pricing Inquiry Accepted/Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø4-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Drug Pricing Inquiry Accepted/Paid
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Drug Pricing Inquiry Accepted/Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	C = Paid	M	
13Ø-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Drug Pricing Inquiry Accepted/Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Response Claim Segment Question	Check	Drug Pricing Inquiry Accepted/Paid
This segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Drug Pricing Inquiry Accepted/Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number	Same value as in request	M	

Response Pricing Segment Question	Check	Drug Pricing Inquiry Accepted/Paid
This segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			Drug Pricing Inquiry Accepted/Paid
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
505-F5	Patient Pay Amount		R	<i>Payer Requirement:</i> This field contains the desired Medi-Cal reimbursement amount including fixed electronic transmission fee
506-F6	Ingredient Cost Paid		R	
509-F9	Total Amount Paid		R	

3.2.2 Accepted/Rejected

Response Transaction Header Segment Question	Check	Drug Pricing Inquiry Accepted/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Drug Pricing Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Drug Pricing Inquiry Accepted/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Drug Pricing Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Drug Pricing Inquiry Accepted/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Drug Pricing Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Drug Pricing Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> Free form messages contains text message area, denial code(s) and eligibility-related Information
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Question	Check	Drug Pricing Inquiry Accepted/Rejected
This segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Drug Pricing Inquiry Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number	Same value as in request	M	

3.2.3 Rejected/Rejected

Response Transaction Header Segment Question	Check	Drug Pricing Inquiry Rejected/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Drug Pricing Inquiry Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Drug Pricing Inquiry Rejected/Rejected
This segment is always used		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Drug Pricing Inquiry Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø4-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Drug Pricing Inquiry Rejected/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Drug Pricing Inquiry Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
51Ø-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
13Ø-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Drug Pricing Inquiry Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
526-FQ	Additional Message Information		RW	<p><i>Imp Guide:</i> Required when additional text is needed for clarification or detail</p> <p><i>Payer Requirement:</i> Free form messages contains text message area, denial code(s) and eligibility-related information</p>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
549-7F	Help Desk Phone Number Qualifier		RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
550-8F	Help Desk Phone Number		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

*****End of Response Drug Pricing Inquiry (B1) Payer Sheet Template*****

4 NCPDP VERSION D.Ø ELIGIBILITY VERIFICATION

4.1 E1 – Eligibility Verification Request

Start of Request Eligibility Verification (E1) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)		Date: December 2Ø11	
Plan Name/Group Name: California Medicaid (Medi-Cal)		BIN: 61Ø442	PCN: N/A

FIELD LEGEND COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When." The situation designated has qualifications for usage (Required if "x", not Required if "y").	Yes

Fields that are not used in the Request Eligibility Verification transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

ELIGIBILITY VERIFICATION REQUEST

The following lists the segments and fields in a Request Eligibility Verification Transaction for *NCPDP Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Question	Check	Eligibility Verification
This segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is not used		

	Transaction Header Segment			Eligibility Verification
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN Number	61Ø442	M	

Transaction Header Segment			Eligibility Verification	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	E1	M	
1Ø4-A4	Processor Control Number	Fill with Spaces	M	
1Ø9-A9	Transaction Count	1	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1 = NPI	M	
2Ø1-B1	Service Provider ID		M	NPI of Submitting Pharmacy
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	PC/POS Version Number-7 Bytes and Submitter ID - 3 Bytes	M	

Insurance Question	Check	Eligibility Verification
This segment is always sent	X	

Insurance Segment Identification (111-AM) = "Ø4"			Eligibility Verification	
Field #	NCPDP Field Name	Values	Payer Usage	Payer Situation
3Ø2-C2	Cardholder Identification Number	Must be one of the following formats: CIN (nine characters) plus the BIC Issue Date (YYMMDD) MEDS ID (nine characters) plus the BIC Issue Date (YYMMDD) BID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters)	M	

Patient Question	Check	Eligibility Verification
This segment is always sent	X	
This segment is situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			Eligibility Verification
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø4-C4	Date of Birth		R	
3Ø5-C5	Patient Gender Code		R	
311-CB	Patient Last Name		R	
3Ø7-C7	Place of Service		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility</p> <p><i>Payer Requirement:</i> Medi-Cal requires a valid POS as defined by ECL</p>

*****End of Request Eligibility Verification (E1) Payer Sheet Template *****

4.2 E1 - Eligibility Verification Response

4.2.1 Accepted/Approved

*****Start of Response Eligibility Verification (E1) Payer Sheet Template *****

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)	Date: December 2Ø11	
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 61Ø442	PCN: N/A

The following lists the segments and fields in a Response Eligibility Transaction (Accepted/Approved) for NCPDP Telecommunication Standard Implementation Guide Version D.Ø.

Response Transaction Header Question	Check	Eligibility Verification Accepted/Approved
This segment is always sent	X	

	Response Transaction Header Segment			Eligibility Verification Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	E1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Eligibility Verification Accepted/Approved
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Eligibility Verification Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Eligibility Verification Accepted/Approved
This segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	A = Approved	M	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text.
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide

4.2.2 Accepted/Rejected

Response Transaction Header Question	Check	Eligibility Verification Accepted/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Eligibility Verification Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	E1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Eligibility Verification Accepted/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Eligibility Verification Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Eligibility Verification Accepted/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Eligibility Verification Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information (Repeat)		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

4.2.3 Rejected/Rejected

Response Transaction Header Question	Check	Eligibility Verification Rejected/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Eligibility Verification Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	E1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Eligibility Verification Rejected/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Eligibility Verification Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status segment Question	Check	Eligibility Verification Rejected/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Eligibility Verification Rejected/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Rejected	M	
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<p><i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
130-UF	Additional Message Information Count		RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
132-UH	Additional Message Information Qualifier		RW	<p><i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
526-FQ	Additional Message Information (Repeat)		RW	<p><i>Imp Guide:</i> Required when additional text is needed for clarification or detail</p> <p><i>Payer Requirement:</i> This field will contain response specific text</p>

	Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
549-7F	Help Desk Phone Number Qualifier		RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
55Ø-8F	Help Desk Phone Number		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

*****End of Response Eligibility Verification (E1) Payer Sheet Template *****

5 NCPDP VERSION D.Ø PRIOR AUTHORIZATION REVERSAL

5.1 P2 – Prior Authorization Reversal Request

*****Start of Request Prior Authorization Reversal (P2) Payer Sheet Template*****

GENERAL INFORMATION

Payer Name: California Medicaid (Medi-Cal)	Date: June 25, 2012	
Plan Name/Group Name: California Medicaid (Medi-Cal)	BIN: 610442	PCN: N/A

FIELD LEGEND COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When." The situation designated has qualifications for usage (Required if "x", not Required if "y").	Yes

Fields that are not used in the Prior Authorization Reversal Request transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template

PRIOR AUTHORIZATION REVERSAL REQUEST TRANSACTION

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

Transaction Header Segment Question	Check	Prior Authorization Reversal
This segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is not used		

Transaction Header Segment			Prior Authorization Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN Number	61Ø442	M	
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	P2	M	
1Ø4-A4	Processor Control Number	Fill with Spaces	M	
1Ø9-A9	Transaction Count	1	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1 = NPI	M	
2Ø1-B1	Service Provider ID		M	NPI of Submitting Pharmacy
4Ø1-D1	Date of Service		M	
11Ø-AK	Software Vendor/Certification ID	PC/POS Version Number – 7 Bytes and Submitter ID – 3 Bytes	M	

Prior Authorization Segment Question	Check	Prior Authorization Reversal
This segment is always sent	X	

Prior Authorization Segment Identification (111-AM) = "12"			Prior Authorization Reversal	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PA	Request Type		M	
498-PB	Request Period Date Begin		M	
498-PC	Request Period Date End		M	
498-PD	Basis of Request		M	
498-PY	Prior Authorization Number Assigned		RW	<i>Imp Guide:</i> Required if known to sender; otherwise send Authorization Number (5Ø3-F3) <i>Payer Requirement:</i> Not Used
5Ø3-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if Prior Authorization Number-Assigned (498-PY) is not known <i>Payer Requirement:</i> This field is required to process the transaction. This element will be assigned a 19-digit number by Medi-Cal and is used by the submitter to track their

			<p>Prior Authorization Request (P4) transaction. It is used in Inquiry (P3) or Reversal (P2) regardless of the status of the Prior Authorization Request (P4). This 19-digit number is composed of the original 10-digit number assigned by Medi-Cal PLUS the 9 digit National Drug Code (5-digit supplier + 4-digit product). Refer to Appendix A for additional requirements</p>
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End of Request Prior Authorization Reversal (P2) Payer Sheet Template

5.2 P2 – Prior Authorization Reversal Response

5.2.1 Accepted/Captured

Start of Response Prior Authorization Reversal (P2) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid	Date: June 25, 2012	
Plan Name/Group Name: California Medicaid	BIN: 610442	PCN: N/A

Response Transaction Header Question	Check	Prior Authorization Reversal Accepted/Captured
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Reversal Accepted/Captured
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	P2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Reversal Accepted/Captured
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Prior Authorization Reversal Accepted/Captured
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Reversal Accepted/Captured
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Prior Authorization Reversal Accepted/Captured
Field #	NCPDP Field Name	Values	Payer Usage	Payer Situation
112-AN	Transaction Response Status	C = Captured or Q = Duplicate of Captured	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text.

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Reversal Accepted/Captured
131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Reversal Accepted/Captured
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
550-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

5.2.2 Accepted/Rejected

Response Transaction Header Question	Check	Prior Authorization Reversal Accepted/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	P2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Reversal Accepted/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Prior Authorization Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Reversal Accepted/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Prior Authorization Reversal Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Reversal Accepted/Rejected
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required if and only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

5.2.3 Rejected/Rejected

Response Transaction Header Question	Check	Prior Authorization Reversal Rejected/Rejected
This segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	P2	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	R = Rejected	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request	M	
2Ø1-B1	Service Provider ID	Same value as in request	M	
4Ø1-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Reversal Rejected/Rejected
This segment is always sent		
This segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "2Ø"			Prior Authorization Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
5Ø4-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Reversal Rejected/Rejected
This segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Prior Authorization Reversal Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
5Ø3-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Reversal Rejected/Rejected
51Ø-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	<i>Imp Guide:</i> Required if a repeating field is in error, to identify repeating field occurrence <i>Payer Requirement:</i> Same as Imp Guide
13Ø-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Reversal Rejected/Rejected
				used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

*****End of Response Prior Authorization Reversal (P2) Payer Sheet Template*****

6 NCPDP VERSION D.Ø PRIOR AUTHORIZATION INQUIRY

6.1 P3 – Prior Authorization Inquiry Request

Start of Request Prior Authorization Inquiry (P3) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid		Date: June 25, 2Ø12
Plan Name/Group Name: California Medicaid	BIN: 61Ø442	PCN: N/A

FIELD LEGEND COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When." The situation designated has qualifications for usage (Required if "x", not Required if "y").	Yes

Fields that are not used in the Request Prior Authorization Inquiry transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template

PRIOR AUTHORIZATION INQUIRY REQUEST

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

Transaction Header Segment Question	Check	Prior Authorization Inquiry
This segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

Field #	Transaction Header Segment	Value	Payer Usage	Prior Authorization Inquiry
1Ø1-A1	NCPDP Field Name			Payer Situation
1Ø1-A1	BIN Number	61Ø442	M	
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	P3	M	

	Transaction Header Segment			Prior Authorization Inquiry
104-A4	Processor Control Number	Fill with Spaces	M	
109-A9	Transaction Count	1	M	
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID		M	NPI of Submitting Pharmacy
401-D1	Date of Service		M	
110-AK	Software Vendor/ Certification ID	PC/POS Version Number – 7 Bytes and Submitter ID – 3 Bytes	M	

Insurance Segment Question	Check	Prior Authorization Inquiry
This segment is always sent	X	

	Insurance Segment Identification (111-AM) = "004"			Prior Authorization Inquiry
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3002-C2	Cardholder Identification Number	Must be 1 of the following format: <ul style="list-style-type: none"> CIN (9 characters) plus the BIC Issue Date (YYMMDD) MEDS ID (9 characters) plus the BIC Issue Date (YYMMDD) BID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters) plus the BIC Issue Date (YYMMDD) BIC ID (14 characters) 	M	

Prior Authorization Segment Question	Check	Prior Authorization Inquiry
This Segment is always sent	X	

	Prior Authorization Segment Identification (111-AM) = "12"			Prior Authorization Inquiry
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
498-PA	Request Type		M	
498-PB	Request Period Date Begin		M	
498-PC	Request Period Date End		M	
498-PD	Basis of Request		M	
498-PY	Prior Authorization Number Assigned		RW	<p><i>Imp Guide:</i> Required if known to sender; otherwise send Authorization Number (5Ø3-F3).</p> <p><i>Payer Requirement:</i> Not Used</p>

	Prior Authorization Segment Identification (111-AM) = "12"			Prior Authorization Inquiry
503-F3	Authorization Number		RW	<p><i>Imp Guide:</i> Required if Prior Authorization Number-Assigned (498-PY) is not known</p> <p><i>Payer Requirement:</i> This field is required to process the transaction. This element will be assigned a 19-digit number by Medi-Cal and is used by the submitter to track their Prior Authorization Request (P4) transaction. It is used in Inquiry (P3) or Reversal (P2) regardless of the status of the Prior Authorization Request (P4). This 19-digit number is composed of the original 10-digit number assigned by Medi-Cal PLUS the 9-digit National Drug Code (5-digit supplier + 4-digit product). Refer to Appendix A for additional requirements.</p>

End of Request Prior Authorization Inquiry (P3) Payer Sheet Template

6.2 P3 – Prior Authorization Inquiry Response

6.2.1 Accepted/Captured

Start of Response Prior Authorization Inquiry (P3) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid	Date: June 25, 2012	
Plan Name/Group Name: California Medicaid	BIN: 610442	PCN: N/A

Response Transaction Header Question	Check	Prior Authorization Inquiry Accepted/Captured
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Inquiry Accepted/Captured
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	P3	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Inquiry Accepted/Captured
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Identification (111-AM) = "20"			Prior Authorization Inquiry Accepted/Captured
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Inquiry Accepted/Captured
This Segment is always sent	X	

	Response Status Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Captured
Field #	NCPDP Field Name	Values	Payer Usage	Payer situation
112-AN	Transaction Response Status	C = Captured	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Captured
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

6.2.2 Accepted/Approved

Response Transaction Header Question	Check	Prior Authorization Inquiry Accepted/Approved
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Inquiry Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer situation</i>
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	P3	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	A = Accepted	M	

202-B2	Service Provider ID Qualifier	Same value as in request	M	
	Response Transaction Header Segment			Prior Authorization Inquiry Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer situation</i>
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Inquiry Accepted/Approved
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Prior Authorization Inquiry Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Inquiry Accepted/Approved
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	A = Approved	M	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Approved
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Question	Check	Prior Authorization Inquiry Accepted/Approved
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Prior Authorization Inquiry Accepted/Approved
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/ Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/ Service Reference Number		M	<i>Imp Guide:</i> Mandatory <i>Payer Requirement:</i> Medi-Cal will always send a Zero

Response Prior Authorization Segment Question	Check	Prior Authorization Inquiry Accepted/Approved
This Segment is always sent	X	

	Response Prior Authorization Segment Identification (111-AM) = "26"			Prior Authorization Inquiry Accepted/Approved
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PR	Prior Authorization Processed Date		R	
498-PS	Prior Authorization Effective Date		RW	<p><i>Imp Guide:</i> Required if the prior authorization has an effective date</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
498-PT	Prior Authorization Expiration Date		RW	<p><i>Imp Guide:</i> Required if the prior authorization has an expiration date</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
498-RA	Prior Authorization Quantity		RW	<p><i>Imp Guide:</i> Required if the total quantity authorized is greater than zero</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
498-RB	Prior Authorization Dollars Authorized		RW	<p><i>Imp Guide:</i> Required if the total dollars authorized is greater than zero</p> <p><i>Payer Requirement:</i> Negotiated Price Dollars Authorized provided to the pharmacy by the processor to be used by the pharmacy to bill the plan. If the prior authorization dollars authorized is \$76.00 this field would reflect: 760 {.</p> <p>This field is only present if the prior authorization is a negotiated price TAR</p>

	Response Prior Authorization Segment Segment Identification (111-AM) = "26"			Prior Authorization Inquiry Accepted/Approved
498-PW	Prior Authorization Number of Refills Authorized		RW	<p><i>Imp Guide:</i> Required if a specific number of refills is authorized</p> <p><i>Payer Requirement:</i> Prior Authorization Number of refills authorized provided to the pharmacy by the processor to be used by the pharmacy for refills. If the value is equal to 99 please refer to the message areas for the exact number of refills authorized on the prior authorization.</p>
498-PY	Prior Authorization Number Assigned		RW	<p><i>Imp Guide:</i> Required if the receiver's system assigns this number</p> <p><i>Payer Requirement:</i> The prior authorization number returned will be the original 10-digit number sent on the input transaction plus an 11th digit containing the pricing indicator</p>

6.2.3 Accepted/Deferred

Response Transaction Header Question	Check	Prior Authorization Inquiry Accepted/Deferred
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Inquiry Accepted/Deferred
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	P3	M	
1Ø9-A9	Transaction Count	Same value as in request	M	
5Ø1-F1	Header Response Status	A = Accepted	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request	M	
2Ø1-B1	Service Provider ID	Same value as in request	M	
4Ø1-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Inquiry Accepted/Deferred
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Prior Authorization Inquiry Accepted/Deferred
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Inquiry Accepted/Deferred
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Deferred
Field #	NCPDP Field Name	Values	Payer Usage	Payer Situation
112-AN	Transaction Response Status	F = Deferred	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Deferred
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text.
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Question	Check	Prior Authorization Inquiry Accepted/Deferred
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Prior Authorization Inquiry Accepted/Deferred
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/ Service Reference	1 = Rx Billing	M	

	Number Qualifier			
402-D2	Prescription/ Service Reference Number		M	<i>Imp Guide: Mandatory</i> <i>Payer Requirement:</i> Medi-Cal will always send a Zero

Response Prior Authorization Segment Question	Check	Prior Authorization Inquiry Accepted/Deferred
This Segment is situational	X	

	Response Prior Authorization Segment Identification (111-AM) = "26"			Prior Authorization Inquiry Accepted/Deferred
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PR	Prior Authorization Processed Date		R	

6.2.4 Accepted/Rejected

Response Transaction Header Question	Check	Prior Authorization Inquiry Accepted/Rejected
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Inquiry Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	P3	M	
109-A9	Transaction Count	Same value as in request	M	
51-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Inquiry Accepted/Rejected
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Prior Authorization Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Inquiry Accepted/Rejected
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		R	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Accepted/Rejected
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Question	Check	Prior Authorization Inquiry Accepted/Rejected
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Prior Authorization Inquiry Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/ Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/ Service Reference Number		M	<i>Imp Guide: Mandatory</i> <i>Payer Requirement: Medi- Cal will always send a Zero</i>

6.2.5 Rejected/Rejected

Response Transaction Header Question	Check	Prior Authorization Inquiry Rejected/Rejected
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Inquiry Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	P3	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Inquiry Rejected/Rejected
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Prior Authorization Inquiry Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Inquiry Rejected/Rejected
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	R = Rejected	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		R	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Inquiry Rejected/Rejected
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
550-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

End of Response Prior Authorization Inquiry (P3) Payer Sheet Template

7 NCPDP VERSION D.Ø PRIOR AUTHORIZATION REQUEST ONLY

7.1 P4 – Prior Authorization Request Only

Start of Request Prior Authorization Request Only (P4) Payer Sheet Template

GENERAL INFORMATION

Payer Name: California Medicaid	Date: June 25, 2012
Plan Name/Group Name: California Medicaid	BIN: 610442 PCN: N/A

FIELD LEGEND COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The field is mandatory for the Segment in the designated Transaction	No
REQUIRED	R	The field has been designated with the situation of "Required" for the Segment in the designated Transaction	No
QUALIFIED REQUIREMENT	RW	"Required When". The situation designated has qualifications for usage. (Required if "x", not Required if "y").	Yes

Fields that are not used in the Request Prior Authorization Request Only transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template

PRIOR AUTHORIZATION REQUEST ONLY

The following lists the segments and fields in a Request Prior Authorization Request Only transaction for NCPDP Telecommunication Standard Implementation Guide Version D. Ø

Transaction Header Segment Question	Check	Prior Authorization Request Only
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID is Payer issued	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used		

Transaction Header Segment	Value	Payer Usage	Prior Authorization Request Only
Field #	NCPDP Field Name		Payer Situation
101-A1	BIN Number	610442	M
102-A2	Version/Release Number	DØ	M
103-A3	Transaction Code	P4	M
104-A4	Processor Control Number	Fill with Spaces	M
109-A9	Transaction Count	1	M

	Transaction Header Segment			Prior Authorization Request Only
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID		M	NPI of Submitting Pharmacy
401-D1	Date of Service		M	
110-AK	Software Vendor/ Certification ID	PC/POS Version Number – 7 Bytes and Submitter ID – 3 Bytes	M	

Insurance Segment Question	Check	Prior Authorization Request Only
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "04"			Prior Authorization Request Only
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	Cardholder Identification Number	Must be 1 of the following format: <ul style="list-style-type: none"> • CIN (9 characters) plus the BIC Issue Date (YYMMDD) • MEDS ID (9 characters) plus the BIC Issue Date (YYMMDD) • BID (14 characters) plus the BIC Issue Date (YYMMDD) • BIC ID (14 characters) plus the BIC Issue Date (YYMMDD) • BIC ID (14 characters) 	M	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Prior Authorization Request Only
312-CC	Cardholder First Name		RW	<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency or Workers' Compensation programs. Required if multiple people have the same Cardholder ID. Required if additional verification of the submitted eligibility information is needed.</p> <p><i>Payer Requirement:</i> Populate this field only when it is different than the Patient First Name/Last Name on the Patient Segment</p>
313-CD	Cardholder Last Name		RW	<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency or Workers' Compensation programs. Required if multiple people have the same Cardholder ID. Required if additional verification of the submitted eligibility information is needed.</p> <p><i>Payer Requirement:</i> Populate this field only when it is different than the Patient First Name/Last Name on the Patient Segment</p>

Patient Segment Question	Check	Prior Authorization Request Only
This Segment is always sent	X	
This Segment is Situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			Prior Authorization Request Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
3Ø4- C4	Date of Birth		R	
3Ø5- C5	Patient Gender Code		RW	<i>Imp Guide:</i> Required if additional verification of the submitted eligibility information is needed. Required if needed to assist in identifying the patient when specific eligibility cannot be established. <i>Payer Requirement:</i> Same as Imp Guide
31Ø- CA	Patient First Name		RW	<i>Imp Guide:</i> Required if the patient is not the cardholder and needed to file the prior authorization request. Required if the patient is not the Cardholder and Date of Birth (3Ø4-C4) is not available. Required if necessary for state/federal/regulatory agency Programs <i>Payer Requirement:</i> Same as Imp Guide
311-CB	Patient Last Name		RW	<i>Imp Guide:</i> Required if the patient is not the cardholder and needed to file the prior authorization <i>Payer Requirement:</i> Same as Imp Guide

	Patient Segment Segment Identification (111-AM) = "Ø1"			Prior Authorization Request Only
3Ø7- C7	Place of Service	12 = Home 13 = Assisted Living Facility 14 = Group Home 20 = Urgent Care Facility 21 = Inpatient Hospital 22 = Outpatient Hospital 23 = Emergency Room 24 = Ambulatory Surgical Center 31 = Skilled Nursing Facility 32 = Nursing Facility 33 = Custodial Care Facility 34 = Hospice 54 = Intermediate Care Facility	RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility <i>Payer Requirement:</i> Medi-Cal requires a valid POS given in the value column.
326- CQ	Patient Phone Number		RW	<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement:</i> Same as Imp Guide

Claim Segment Question	Check	Prior Authorization Request Only
This Segment is always sent	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Prior Authorization Request Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/ Service Reference Number Qualifier	1 = RX Billing	M	
4Ø2-D2	Prescription/ Service Reference Number		M	
	Claim Segment Segment Identification (111-AM) = "Ø7"			Prior Authorization Request Only

436-EI	Product/Service ID Qualifier	Ø3 = National Drug Code NDC ØØ = Compound drug	M	
4Ø7-D7	Product/Service ID	For compound drugs this field should be Zero	M	
442-E7	Quantity Dispensed	For compound drug, this should be the amount of the entire multi-ingredient product	R	
4Ø5-D5	Days Supply		R	
4Ø6-D6	Compound Code	1 = Not Compound 2 = Compound	RW	<i>Imp Guide:</i> Required if requesting a prior authorization for a compound (Compound Code (4Ø6-D6) = 2) <i>Payer Requirement:</i> Same as Imp Guide
4Ø8-D8	Dispense as Written (DAW)/Product Selection Code		RW	<i>Imp Guide:</i> Required if this field results in different coverage <i>Payer Requirement:</i> Same as Imp Guide
415-DF	Number of Refills Authorized		R	
995-E2	Route of Administration		RW	<i>Imp Guide:</i> Required if an override to the "default" route of administration is specified for the product. For a multi-ingredient compound, it is the route of the complete compound mixture. <i>Payer Requirement:</i> Required when billing compound drugs

Prior Authorization Segment Question	Check	Prior Authorization Request Only
This Segment is always sent	X	

	Prior Authorization Segment Identification (111-AM) = "12"			Prior Authorization Request Only
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
498-PA	Request Type		M	

	Prior Authorization Segment Identification (111-AM) = "12"			Prior Authorization Request Only
498-PB	Request Period Date Begin		M	
498-PC	Request Period Date End		M	
498-PD	Basis of Request		M	
498-PE	Authorized Representative First Name		RW	<i>Imp Guide:</i> Required if needed for prior authorization determination <i>Payer Requirement:</i> Same as Imp Guide
498-PF	Authorized Representative Last Name		RW	<i>Imp Guide:</i> Required if needed for prior authorization determination <i>Payer Requirement:</i> Same as Imp Guide
498-PG	Authorized Representative Street Address		RW	<i>Imp Guide:</i> Required if needed for prior authorization determination <i>Payer Requirement:</i> Same as Imp Guide
498-PH	Authorized Representative City Address		RW	<i>Imp Guide:</i> Required if needed for prior authorization determination <i>Payer Requirement:</i> Same as Imp Guide
498-PJ	Authorized Representative State/Province Address		RW	<i>Imp Guide:</i> Required if needed for prior authorization determination <i>Payer Requirement:</i> Same as Imp Guide
498-PK	Authorized Representative Zip/Postal Zone		RW	<i>Imp Guide:</i> Required if needed for prior authorization determination <i>Payer Requirement:</i> Same as Imp Guide

	Prior Authorization Segment Identification (111-AM) = "12"			Prior Authorization Request Only
498-PY	Prior Authorization Number Assigned		RW	<p><i>Imp Guide:</i> Required if known to sender</p> <p><i>Payer Requirement:</i> This field should be used to submit the prior authorization number when the original prior authorization request received a response of 'A' (Approved). The first 10 digits should contain the original TCN and the 11th digit should contain the pricing indicator that is returned as part of the TCN on an approved TAR.</p>
498-PP	Prior Authorization Supporting Documentation		RW	<p><i>Imp Guide:</i> Required if additional information is needed for prior authorization determination</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Prescriber Segment Question	Check	Prior Authorization Request Only
This Segment is situational	X	

	Prescriber Segment Identification (111-AM) = "Ø3"			Prior Authorization Request Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	Prescriber ID Qualifier	Ø1= NPI	RW	<p><i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used</p> <p><i>Payer Requirement:</i> Medi-Cal requires this field</p>
411-DB	Prescriber ID		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage or patient</p>

				financial responsibility Required if necessary for state/federal/regulatory agency programs <i>Payer Requirement:</i> Medi-Cal requires NPI of the prescriber
427-DR	Prescriber Last Name		RW	<i>Imp Guide:</i> Required when the Prescriber ID (411-DB) is not known. <i>Payer Requirement:</i> Same as Imp Guide
498-PM	Prescriber Phone Number		RW	<i>Imp Guide:</i> Required if needed to assist in identifying the prescriber. <i>Payer Requirement:</i> Same as Imp Guide

Compound Segment Question	Check	Prior Authorization Request Only
This Segment is always sent		
This Segment is situational	X	Required for submitting compound drug

	Compound Segment Segment Identification (111-AM) = "1Ø"			Prior Authorization Request Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
45Ø-EF	Compound Dosage Form Description Code		M	
451-EG	Compound Dispensing Unit Form Indicator		M	
447-EC	Compound Ingredient Component Count	Medi-Cal supports up to 24 compound product IDs and 1 for the container count (25 Product IDs if a container count is included)	M	
488-RE	Compound Product ID Qualifier	Ø3 = National Drug Code (NDC) 99 = Other (Container Count) Must be accompanied with 9999999997 in field 489-TE. When a product ID of all 9999999997 is submitted then the quantity in field 448-ED will be considered the Container Count.	M	
489-TE	Compound Product ID	NDC Number When specifying the number of containers as an ingredient the NDC should be equal to 9999999997	M	
448-ED	Compound Ingredient Quantity		M	<i>Payer Requirement:</i> Used to indicate number of containers for compound drugs when Compound Product ID is 9999999997 and Compound Product ID Qualifier is 99 Maximum allowed is 999 containers

Clinical Segment Question	Check	Prior Authorization Request Only
This Segment is always sent		
This Segment is situational	X	Please see Pharmacy Provider Manual for diagnosis code submission requirements

	Clinical Segment Segment Identification (111-AM) = "13"			Prior Authorization Request Only
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	Diagnosis Code Count	Medi-Cal supports one or two diagnosis codes	RW	<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-D.O) are used <i>Payer Requirement:</i> Same as Imp Guide
492-WE	Diagnosis Code Qualifier	Ø1= International Classification of Diseases (ICD-9-CM)	RW	<i>Imp Guide:</i> Required if Diagnosis Code (424-D. Ø) is used <i>Payer Requirement:</i> Same as Imp Guide
424-D.Ø	Diagnosis Code		RW	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs <i>Payer Requirement:</i> Same as Imp Guide

	Clinical Segment Segment Identification (111-AM) = "13"			Prior Authorization Request Only
493-XE	Clinical Information Counter		RW	<p><i>Imp Guide:</i> Maximum of 5 occurrences supported.</p> <p><i>Payer Requirement:</i> Medi-Cal supports up to 2 sets of clinical information: One for the height in inches and the other for the weight in pounds.</p> <p>Medi-Cal will accept all occurrences of the clinical information that are sent but will only utilize the last weight and last height occurrence found. All others will be bypassed. Occurrence number for the following set of fields:</p> <ul style="list-style-type: none"> • Measurement Dimension • Measurement Units • Measurement Value
496-H2	Measurement Dimension	14 = Height 16 = Weight	RW	<p><i>Imp Guide:</i> Required if Measurement Unit (497-H3) and Measurement Value (499-H4) is used. Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization.</p> <p>Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN).</p> <p><i>Payer Requirement:</i> Must be present with counter value found in field 493-XE</p>

	Clinical Segment Segment Identification (111-AM) = "13"			Prior Authorization Request Only
497-H3	Measurement Unit	Ø1 = Inches Ø3 = Pounds		<p><i>Imp Guide:</i> Required if Measurement Dimension (496-H2) and Measurement Value (499-H4) are used. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN).</p> <p>Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization.</p> <p><i>Payer Requirement:</i> Must be present with counter value found in field 493-XE</p>
499-H4	Measurement Value		RW	<p><i>Imp Guide:</i> Required if Measurement Dimension (496-H2) and Measurement Unit (497-H3) are used. Required if necessary for patient's weight and height when billing Medicare for a claim that includes a Certificate of Medical Necessity (CMN).</p> <p>Required if necessary when this field could result in different coverage and/or drug utilization review outcome and is a requirement for authorization.</p> <p><i>Payer Requirement:</i> Must be present with counter value found in field 493-XE.</p> <p>The measurement value cannot be more than 99 when submitting a height measurement or 999 when submitting a weight measurement.</p> <p>If more than 3 characters are sent then the transaction will be rejected</p>

*****End of Request Prior Authorization Request Only (P4) Payer Sheet Template*****

7.2 P4 – Prior Authorization Request Only Response

7.2.1 Accepted/Captured

*****Start of Response Prior Authorization Request Only (P4) Payer Sheet Template*****

GENERAL INFORMATION

Payer Name: California Medicaid	Date: June 25, 2012	
Plan Name/Group Name: California Medicaid	BIN: 610442	PCN: N/A

Response Transaction Header Question	Check	Prior Authorization Request Only Accepted/Captured
This Segment is always sent	X	

Field #	Response Transaction Header Segment	Value	Payer Usage	Prior Authorization Request Only Accepted/Captured
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	P4	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Request Only Accepted/Captured
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

Field #	Response Message Segment Identification (111-AM) = "20"	Value	Payer Usage	Prior Authorization Request Only Accepted/Captured
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation

	Response Message Segment Segment Identification (111-AM) = "20"			Prior Authorization Request Only Accepted/Captured
504-F4	Message		RW	<i>Imp Guide:</i> Required if text is needed for clarification or detail <i>Payer</i> <i>Requirement:</i> Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Request Only Accepted/Captured
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Request Only Accepted/Captured
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Values</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
112-AN	Transaction Response Status	C = Captured	M	
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text

131-UG	Additional Message Information Continuity		RW	<p><i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
549-7F	Help Desk Phone Number Qualifier		RW	<p><i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>
55Ø-8F	Help Desk Phone Number		RW	<p><i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver</p> <p><i>Payer Requirement:</i> Same as Imp Guide</p>

Response Claim Segment Question	Check	Prior Authorization Request Only Accepted/Captured
This Segment is always sent	X	

Response Claim Segment Identification (111-AM) = "22"		Prior Authorization Request Only Accepted/Captured		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/ Service Reference Number Qualifier	1 = Rx Billing	M	
4Ø2-D2	Prescription/ Service Reference Number		M	

7.2.2 Accepted/Rejected

Response Transaction Header Question		Check	Prior Authorization Request Only Accepted/Rejected	
This Segment is always sent		X		
	Response Transaction Header Segment			Prior Authorization Request Only Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	DØ	M	
103-A3	Transaction Code	P4	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question		Check	Prior Authorization Request Only Accepted/Rejected
This Segment is always sent			
This Segment is situational		X	Provide general information when used for transmission-level messaging

	Response Message Segment Segment Identification (111-AM) = "20"			Prior Authorization Request Only Accepted/Rejected
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Imp Guide: Required if text is needed for clarification or detail Payer Requirement: Same as Imp Guide

Response Status Segment Question		Check	Prior Authorization Request Only Accepted/Rejected
This Segment is always sent		X	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Request Only Accepted/Rejected
Field #	NCPDP Field Name	Values	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Rejected	M	

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Request Only Accepted/Rejected
503-F3	Authorization Number		RW	<i>Imp Guide:</i> Required if needed to identify the transaction <i>Payer Requirement:</i> Same as Imp Guide
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		R	
130-UF	Additional Message Information Count		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text.
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current <i>Payer Requirement:</i> Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Request Only Accepted/Rejected
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (550-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
550-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

Response Claim Segment Question	Check	Prior Authorization Request Only Accepted/Rejected
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Prior Authorization Request Only Accepted/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	Prescription/ Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/ Service Reference Number		M	

7.2.3 Rejected/Rejected

Response Transaction Header Question	Check	Prior Authorization Request Only Rejected/Rejected
This Segment is always sent	X	

	Response Transaction Header Segment			Prior Authorization Request Only Rejected/Rejected
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	P4	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	

202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Question	Check	Prior Authorization Request Only Rejected/Rejected
This Segment is always sent		
This Segment is situational	X	Provide general information when used for transmission-level messaging

Field #	Response Message Segment Segment Identification (111-AM) = "20"	Value	Payer Usage	Prior Authorization Request Only Rejected/Rejected
	NCPDP Field Name			Payer Situation
504-F4	Message		RW	Imp Guide: Required if text is needed for clarification or detail Payer Requirement: Same as Imp Guide

Response Status Segment Question	Check	Prior Authorization Request Only Rejected/Rejected
This Segment is always sent	X	

Field #	Response Status Segment Segment Identification (111-AM) = "21"	Values	Payer Usage	Prior Authorization Request Only Rejected/Rejected
	NCPDP Field Name			Payer Situation
112-AN	Transaction Response Status	R = Rejected	M	
503-F3	Authorization Number		RW	Imp Guide: Required if needed to identify the transaction Payer Requirement: Same as Imp Guide
510-FA	Reject Count		R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		R	
130-UF	Additional Message Information Count		RW	Imp Guide: Required if Additional Message Information (526-FQ) is used Payer Requirement: Same as Imp Guide

	Response Status Segment Segment Identification (111-AM) = "21"			Prior Authorization Request Only Rejected/Rejected
132-UH	Additional Message Information Qualifier		RW	<i>Imp Guide:</i> Required if Additional Message Information (526-FQ) is used <i>Payer Requirement:</i> Same as Imp Guide
526-FQ	Additional Message Information		RW	<i>Imp Guide:</i> Required when additional text is needed for clarification or detail <i>Payer Requirement:</i> This field will contain response specific text
131-UG	Additional Message Information Continuity		RW	<i>Imp Guide:</i> Required only if current repetition of Additional Message Information (526-FQ) is used. Another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. <i>Payer Requirement:</i> Same as Imp Guide
549-7F	Help Desk Phone Number Qualifier		RW	<i>Imp Guide:</i> Required if Help Desk Phone Number (55Ø-8F) is used <i>Payer Requirement:</i> Same as Imp Guide
55Ø-8F	Help Desk Phone Number		RW	<i>Imp Guide:</i> Required if needed to provide a support telephone number to the receiver <i>Payer Requirement:</i> Same as Imp Guide

*****End of Response Prior Authorization Request Only (P4) Payer Sheet Template*****

8 Appendix A

The intent of this section is to clarify the variance in the usage of two elements in the Prior Authorization transactions. The elements are the 498-PY (Prior Authorization Number Assigned) and the 5Ø3-F3 (Authorization Number) in Versions 5.1 and D.Ø of the NCPDP Standards.

Version 5.1

5Ø3-F3 Authorization number: This element is assigned a 10-digit number by Medi-Cal and is used by the submitter (Provider) to track their Prior Authorization Request (P4) Transaction and is used in the Inquiry (P3) or Reversal (P2) when the Status of a Prior Authorization Request is in a Captured, Deferred or Denied Status.

498-PY Prior Authorization Number Assigned: This element is an 11-digit number composed of the 5Ø3-F3 + 1-digit pricing indicator. This element is used by the submitter to request an update to an approved Prior Authorization using the (P4) or to Reverse (P2) an approved Prior Authorization that has been approved. It also can be used to Inquire (P3) about an approved Prior Authorization.

Version D.Ø

5Ø3-F3 Authorization number: This element will be assigned a 19-digit number by Medi-Cal and is used by the submitter to track their Prior Authorization Request (P4) transaction. It is used in Inquiry (P3) or Reversal (P2) regardless of the status of the Prior Authorization Request (P4). This 19-digit number is composed of the original 10-digit number assigned by Medi-Cal PLUS the 9-digit National Drug Code (5-digit supplier + 4 digit product).

498-PY Prior Authorization Number Assigned: This element will continue to be an 11-digit number and can only be used to send an update/change to an approved Prior Authorization using the (P4). Also, this number is transitioned to be used in the claim billing for payment. This element cannot be used for Inquiry (P3) or Reversal (P2).

Transition from version 5.1 to D.Ø Requirements

All Prior Authorizations submitted to Medi-Cal prior to the submitter transitioning to D.Ø will continue to be valid. However, the submitter must follow these instructions to Inquire, Reverse and Update under version D.Ø.

For P2 Reversal and P3 Inquiry Transactions: The submitter will have to send a 19-digit number on the 5Ø3-F3. This number is composed of the original 10-digit number sent on the 5Ø3-F3 under version 5.1 plus the 9-digit National Drug Code (5-digit supplier + 4-digit product). An example is listed below:

Version 5.1 (5Ø3-F3): 2344225193

Version D.Ø (5Ø3-F3): 5Ø3-F3 Version 5.1 + 9 digit NDC (5-digit Supplier + 4-digit Product)

Version D.Ø (5Ø3-F3) example: 2344225193+5Ø419+Ø862

For P4 Request Transactions: The submitter will have to send the 498-PY, if known