Third Party Transmit Queue Overview

The TP Transmit Queue window lets you view the status of third party claims. You can view detailed claim and pricing information for each prescription as well as the response received from the third party. Also, you can transmit claims that are in downtime or were placed in the queue to await the completion of contracts with a third party.

Transmit Downtime Claim

To transmit a claim that was previously placed in downtime:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** option to **Downtime** and select **Refresh**.
3. Highlight the claim you want to transmit and select **Transmit**.

Transmit Pending Contracts Claim

To transmit a claim that was previously placed in a pending contracts status:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** option to **Pending Contracts** and select **Refresh**.
3. Highlight the claim you want to transmit and select **Transmit**.

Third Party Transmit Queue Window

To access the Third Party Transmit Queue window, select **Tools > TP Transmit Queue**.

The following describes the fields on the Third Party Transmit Queue window.

Status	Determines which claims the system displays based on the claim status **Blank** = system displays all claims **Waiting** = system has not started to transmit the claim **Sending** = system is in the process of transmitting the claim **Received** = system has received a response from the third party for the claim **Complete** = system has created a transaction for the claim **Send Credit** = system is in the process of reversing the claim **Credit** = system sent a reversal request to the third party and received a response If the third party accepted the claim reversal, the system displays **Credit** in the Paid column. **Downtime** = system has not started to transmit the claim because it was placed in downtime **Pending Contracts** = system has not transmitted the claim because you are not yet contracted to submit claims to the third party **Pending Completion Fill** = system has not transmitted the claim because it is for the completion of a partial fill **Cancelled** = claim was cancelled **Not Transmitted** = system has not transmitted the claim because it was a paper (non-adjudicated) claim
Patient Last Name	Patient's last name
Region	Region in which this out-patient pharmacy is located
MRN Prefix	Location ID for the MRN Note: For regions other than NCA (Northern California) and SCA (Southern California), this field is not required.
MRN	Patient's local or home medical record number

Carrier ID	Carrier identification code for the third party
BIN	Bank identification number for the claim
KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Rx Number	Prescription number associated with the claim
Fill Date	Date the prescription was filled
Transmit Date	Date and time the transaction was sent to the third party
Refresh	Select to display the claims based on the criteria you entered.

Third Party Claims

Status	Current status of the claim **Waiting** = system has not started to transmit the claim **Sending** = system is in the process of transmitting the claim **Received** = system has received a response from the third party for the claim **Complete** = system has created a transaction for the claim **Send Credit** = system is in the process of reversing the claim **Credit** = system sent a reversal request to the third party and received a response The system displays **Credit** in the Paid column if the third party accepted the claim reversal or if a paper (non-adjudicated) claim was successfully reversed. **Downtime** = system has not started to transmit the claim because it was placed in downtime **Pending Contracts** = system has not transmitted the claim because you are not yet contracted to submit claims to the third party **Pending Completion Fill** = system has not transmitted the claim because it is for the completion of a partial fill **Cancelled** = claim was cancelled **Not Transmitted** = system has not transmitted the claim because

	it was a paper (non-adjudicated) claim.
Seq.	Third party billing sequence (Primary, Secondary, etc.)
Carrier ID	Carrier identification code to which the claim was submitted
Plan Name	Name of the insurance plan to which the claim was submitted
BIN	Bank identification number for the claim
KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does not change.
Rx Number	Prescription number associated with the claim
Fill Date	Date you filled the prescription
Transmit Date	Date and time the transaction was sent to the third party
Patient Name	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Drug Name	Name of the dispensed drug
Paid	Payment status of the claim **Paid** = third party paid the claim in full **Part** = third party partially paid for the claim **Rejected** = third party rejected the claim **Credit** = third party accepted a reversal for the claim This status also indicates that you successfully reversed a paper (non-adjudicated) claim. **Low Pay** = difference between the amount you submitted for payment and the amount the third party paid was greater than the low pay amount defined on the insurance plan record
	Select to transmit a claim with a status of **Downtime** or **Pending Contracts**. **Note**: The system enables this button only when you select a claim with one of those statuses.
	Select to display additional search results or narrow your search

criteria and select **Refresh**.

View Transmit Detail	Select to view detailed information about a selected claim.
View Response Detail	Select to view detailed information contained in the third party's response.
View Pricing Detail	Select to view pricing information for a selected claim.
List Transmit History	Select to view the records for each transmission of a selected claim.

Claim Response Detail Window - Page 1

To access page 1 of the Claim Response Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Response Detail**.
4. On the Claim Response Detail window, select **Page 1**.

The following describes the fields on page 1 of the Claim Response Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Response File	Select to view the claim response file the third party transmitted. The system displays the View Response File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer

Response Header Segment

A2 Version Number	NCPDP version number **51** = version 5.1 **D0** = version D.0 When you open this window from **Administration** > **Rebill**, you can change the version. This enables you to rebill a 5.1 claim and submit it as a D.0 claim.
A3 Transaction Code	Code that indicates the type of transaction **B1** = Billing **B2** = Reversal **B3** = Rebill **P1** = Prior Authorization Request and Billing **P2** = Prior Authorization Reversal **P3** = Prior Authorization Inquiry **P4** = Prior Authorization Request Only **N1** = Information Reporting **N2** = Information Reporting Reversal **N3** = Information Reporting Rebill **C1** = Controlled Substance Reporting **C2** = Controlled Substance Reporting Reversal **C3** = Controlled Substance Reporting Rebill
A9 Transaction Count	Total number of transactions in the claim submission **Blank** = Not Specified **1** = One Occurrence **2** = Two Occurrences **3** = Three Occurrences **4** = Four Occurrences
F1 Response Status	Code that indicates the status of the transmission **A** = Accepted **R** = Rejected

B2 Provider ID Qualifier	NCPDP service provider ID qualifier Blank = Not Specified **01** = National Provider Identifier (NPI) **02** = Blue Cross **03** = Blue Shield **04** = Medicare **05** = Medicaid **06** = UPIN **07** = NCPDP Provider ID **08** = State License **09** = Champus **10** = Health Industry Number (HIN) **11** = Federal Tax ID **12** = Drug Enforcement Administration (DEA) **13** = State Issued **14** = Plan Specific **99** = Other
B1 Provider ID	Service provider ID assigned by the third party
D1 Fill Date	Date you filled the prescription

Response Message Segment - 20

F4 Message	Free-format response message

Response Status Segment - 21

AN Tx Response Status	Code that indicates the status of the transaction **A** = Approved **C** = Captured **D** = Duplicate of Paid **F** = PA Deferred **P** = Paid **Q** = Duplicate of Capture **R** = Rejected **S** = Duplicate of Approved
F3 Authorization Num.	Number assigned by the processor to identify an authorized transaction
7F Help Desk	Code that identifies the help desk location

Qualifier	**Blank** = Not Specified **01** = Switch **02** = Intermediary **03** = Processor/PBM **99** = Other
8F Help Desk Phone	Help desk phone number
FA Reject Count	Total number of reject codes returned by the third party
FB and 4F Reject Code and Occurrence Indic	Rejection codes and counter number or occurrence of the field that is being rejected
View Reject Description	Select to display the View Reject Description window where you can view descriptions of the rejection codes returned by the third party.
5F Approved Mesg Count	Total number of approved message codes returned by the third party
6F Approved Message Codes	Message code on an approved claim that indicates the need for an additional follow-up
FQ Additional Message	Additional free-format response message (for NCPDP D.0, accepts up to 200 characters)

Claim Response Detail Window - Page 2

To access page 2 of the Claim Response Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Response Detail**.
4. On the Claim Response Detail window, select **Page 2**.

The following describes the fields on page 2 of the Claim Response Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Response File	Select to view the claim response file the third party transmitted. The system displays the View Response File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer

Response Claim Segment - 22

EM Rx/Service # Qual	NCPDP prescription/service ID qualifier **Blank** = Not specified **1** = Prescription Billing **2** = Service Billing
D2 Rx/Service Number	Reference number assigned by the provider for the dispensed drug/product and/or service provider
9F Preferred Prod Cnt	Total number of preferred product fields submitted
AP Product ID Qualifier	Code identifying the type of product ID specified in **AR Product ID** (such as NDC or GCN)
AR Product ID	Alternate product recommended by the plan
AS Incentive	Amount of pharmacy incentive available for substitution of the preferred product
AT Copay Incentive	Amount of patient's copay/cost-share incentive for the preferred product
AU Description	Free text description of the preferred product

Response DUR/PPS Segment - 24

J6 DUR/PPS Counter	Total number of DUR/PPS fields
E4 Reason	Code identifying the type of utilization conflict or the reason for the pharmacist's professional service
FS Significance	Code identifying the significance or severity level of a clinical event **Blank** = Not specified **1** = Major; indicates that an event, transaction, etc. is extremely important; action is required to prevent an adverse drug event **2** = Moderate; indicates that an event, transaction, etc. is of mid-

	level significance; requires thoughtful review before prescribing/dispensing the medication **3** = Minor; indicates a non-life threatening effect that might or might not require a change in drug therapy **9** = Undetermined; a professional service with variable or unknown severity
FT Other Pharmacy	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict **0** = Not specified **1** = Indicates the pharmacy dispensing the current drug is the same as the pharmacy dispensing the conflicting drug **2** = Indicates the pharmacy dispensing the drug is in the same chain as the pharmacy dispensing the conflicting drug **3** = Indicates the pharmacy dispensing the current drug is not the same as the pharmacy of the conflicting drug
FU Date Filled	Date prescription was previously filled
FV Fill Quantity	Amount expressed in metric decimal units of the conflicting agent that was previously filled
FW Database	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product **1** = First DataBank **2** = Medi-Span
FX Other Doctor	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription **0** = Not specified **1** = Indicates the prescriber of the current drug is the same as the prescriber of the conflicting drug **2** = Indicates the prescriber of the current drug is not the same as the prescriber of the conflicting drug
FY Free Text Message	Text that provides additional detail regarding a DUR conflict
NS DUR Additional Text	Descriptive information that further defines the referenced DUR alert

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Claim Response Detail Window - Page 3

To access page 3 of the Claim Response Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Response Detail**.
4. On the Claim Response Detail window, select **Page 3**.

The following describes the fields on page 3 of the Claim Response Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Response File	Select to view the claim response file the third party transmitted. The system displays the View Response File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer

Response Pricing Segment - 23

Patient Responsibility Amounts

FH Amount Attributed to Periodic Deductible (NCDPD 5.1)	Amount the patient owes for this prescription that is applied to the periodic deductible (included in the patient pay amount)
FI Amount of Copay (NCPDP D.0)	Patient's copay amount for the prescription (included in the patient pay amount)
4U Amount of Coinsurance (NCPDP D.0)	Patient's co-insurance amount for the prescription (included in the patient pay amount)
FK Amount Exceeding Periodic Benefit Maximum (NCDPD 5.1)	Amount owed because the patient exceeded a periodic maximum benefit (included in the patient pay amount)
NZ Amount Attributed to Processor Fee (NCPDP D.0)	Amount the patient owes that is for the processor's processing fee (included in the patient pay amount)
FN Attributed to Tax (NCDPD 5.1)	Amount the patient owes that is for sales tax (included in the patient pay amount)
UJ Amount Attributed-Provider Network Selection (NCPDP D.0)	Amount owed because the patient selected an out-of-network provider (included in the patient pay amount)
UK Amt Attrib-Prod Sel-Brand (NCPDP D.0)	Amount owed because the patient selected a brand product (included in the patient pay amount)

UM Amt Attrib-Prod Sel-Non-Prefered (NCPDP D.0)	Amount owed because the patient selected a non-preferred formulary product (included in the patient pay amount)
UN Amt Attrib-Prod Sel-Brand-Non-Prefered (NCPDP D.0)	Amount owed because the patient selected a brand non-preferred formulary product (included in the patient pay amount)
UP Amount Attributed to Coverage Gap (NCPDP D.0)	Amount owed because the patient is in the = 4 && typeof(BSPSPopupOnMouseOver) == 'function') BSPSPopupOnMouseOver(event);" class="BSSCPopup" onclick="BSSCPopup('Coverage_Gap_Definition.htm');return false;">coverage gap, such as the Medicare Part D Coverage Gap ("donut hole") This amount is included in the patient pay amount.
UD Health Plan-Funded Assistance Amount (NCPDP D.0)	Amount from the health plan-funded assistance account for the patient that was applied to reduce Patient Pay Amount (F5) This amount is used in Healthcare Reimbursement Account (HRA) benefits only. This field is always a negative amount or zero.
F5 Patient Pay Amount (NCDPD 5.1)	Total amount the claims processor calculates that the patient owes the pharmacy

Benefit Stage Amount (NCPDP D.0)

MU Benefit Stage Amount Count	Number of **Benefit Stage Amount** (**MW**) occurrences
MV and MW Benefit Stage Amount/Qualifier	**MV Amount** - amount of claim allocated to the Medicare stage identified by the **Benefit Stage Qualifier** **MW Qualifier -** code qualifying the Benefit Stage Amount **01** = Deductible - amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer **02** = Initial Benefit - first monthly benefit, or the first monthly benefit following any break in participation **03** = Coverage Gap (donut hole) - commonly referred to as the "donut hole" Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the

	total out-of-pocket paid for covered prescription drugs reaches a certain amount. **04** = Catastrophic Coverage - after a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year.

Paid Amounts (NCDPD 5.1)

F6 Ingredient Cost	Amount of the drug ingredient cost paid This amount is included in the total amount paid (**F9 Total Amount Paid** field).
F7 Dispensing Fee	Amount of the dispensing fee paid This amount is included in the total amount paid (**F9 Total Amount Paid** field).
J1 Prof. Service Fee	Amount of the contractually agreed upon fee paid for professional services rendered This amount is included in the total amount paid (**F9 Total Amount Paid** field).
FL Incentive	Amount of the contractually agreed upon incentive fee paid for specific services rendered This amount is included in the total amount paid (**F9 Total Amount Paid** field).
AV Tax Exempt Indic.	Code that indicates whether the payer is exempt from paying taxes Blank = Not Specified **1** = Tax Exempt **2** = Non Tax Exempt
AW Flat Sales Tax	Amount of flat sales tax paid This amount is included in the total amount paid (**F9 Total Amount Paid** field).
AX % Sales Tax Amount	Amount of percentage sales tax paid This amount is included in the total amount paid (**F9 Total Amount Paid** field).
AY % Sales Tax Rate	Rate used to calculated the percentage sales tax paid
AZ % Sales Tax Basis	Code that indicates the percentage sales tax paid basis **Blank** = Not Specified **01** = Gross Amount Due

	02 = Ingredient Cost **03** = Ingredient Cost + Dispensing Fee
J5 Other Payer $ Recogn.	Total dollar amount of any payment from another source, including coupons
J2 Other Amount Count	Total number of other amount paid fields Other amount paid fields include **J3-Other Amount Paid Qualifier** and **J4-Other Amount Paid**.
F9 Total Amount Paid	Total amount to be paid by the claims processor
J2 Other Amount Count	Total number of other amount paid fields Other amount paid fields include **J3-Other Amount Paid Qualifier** and **J4-Other Amount Paid**.
J4 and J3 Other Amount Paid/Qualifier	Code that indicates the other amount paid type **Blank** = Not Specified **01** = Delivery **02** = Shipping **03** = Postage **04** = Administrative **09** = Compound Preparation Cost Paid **99** = Other

Basis of Calculation

HH Dispensing Fee (NCDPD 5.1)	Code that indicates how the reimbursement amount was calculated for the dispensing fee **00** = Not Specified **01** = Quantity Dispensed **02** = Quantity Intended to be Dispensed **03** = Usual and Customary/Prorated **04** = Waived due to Partial Fill **99** = Other
HJ Copay (NCDPD 5.1)	Code that indicates how the copay reimbursement amount was calculated for the patient pay amount **00** = Not Specified **01** = Quantity Dispensed **02** = Quantity Intended to be Dispensed **03** = Usual and Customary/Prorated

	04 = Waived due to Partial Fill **99** = Other
K Flat Sales Tax (NCDPD 5.1)	Code that indicates how the reimbursement amount was calculated for the flat sales tax amount **00** = Not Specified **01** = Quantity Dispensed **02** = Quantity Intended to be Dispensed
HM % Sales Tax (NCDPD 5.1)	Code that indicates how the reimbursement amount was calculated for the percentage sales tax amount **00** = Not Specified **01** = Quantity Dispensed **02** = Quantity Intended to be Dispensed
4V Coinsurance (NCDPD D.0)	Code indicating how the coinsurance reimbursement amount was calculated for the patient pay amount
EQ Patient Sales Tax (NCDPD D.0)	Patient sales tax responsibility This field is not a component of the patient pay amount formula.
2Y Plan Sales Tax (NCDPD D.0)	Plan sales tax responsibility This field is not a component of the patient pay amount formula.

Other Amounts

FC Ded. Accumulated (NCDPD 5.1)	Amount met by the patient in a deductible plan
FD Ded. Remaining (NCDPD 5.1)	Amount not met by the patient in a deductible plan
FE Remaining Benefit (NCDPD 5.1)	Amount remaining in a plan with a periodic maximum benefit
FM Basis Reimb Det (NCDPD 5.1)	Code that indicates how the reimbursement amount was calculated **0** = Not Specified **1** = Ingredient Cost Paid as Submitted **2** = Ingredient Cost Reduced to AWP Pricing **3** = Ingredient Cost Reduced to AWP Less [x]% Pricing **4** = Usual and Customary Paid as Submitted

	5 = Paid Lower of Ingredient Cost Pluse Fees versus Usual and Customary **6** = MAC Pricing Ingredient Cost Paid **7** = MAC Pricing Ingredient Cost Reduced to MAC **8** = Contract Pricing **9** = Acquisition Pricing
G3 Estimated Generic Savings (NCDPD D.0)	Estimated amount saved from using generic drugs
UC Spending Account Amt. Rem. (NCDPD 5.1)	Usual and customary amount reimbursed

Claim Response Detail Window - Page 4

Page 4 of the Claim Response Detail Window reflects changes for the NCPDP D.0 telecommunication standard.

To access page 4 of the Claim Response Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Response Detail**.
4. On the Claim Response Detail window, select **Page 4**.

The following describes the fields on page 4 of the Claim Response Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on

	the Insurance Plan Transmit window)
Plan ID	Unique plan number
Plan Name	Name of the insurance carrier
View Response File	Select to view the claim response file the third party transmitted. The system displays the View Response File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer

Response Insurance Segment - 25

C1 Group ID (NCPDP 5.1)	ID number assigned to the cardholder group or employer group
F0 Plan ID (NCPDP 5.1)	ID number assigned by the claims processor to identify a set of parameters, benefit, or coverage criteria used to adjudicate a claim
2F Network Reimb ID (NCPDP 5.1)	ID number assigned by the claims processor to identify the network used to calculate the reimbursement amount to the pharmacy
J7 Payer ID Qualifier (NCPDP 5.1)	Code that indicates the type of payer ID **Blank** = Not Specified **01** = National Payer ID **02** = Health Industry Number (HIN) **03** = Bank Information Number (BIN) **04** = National Association of Insurance Commissioners (NAIC) **99** = Other
J8 Payer ID (NCPDP 5.1)	ID number assigned to the payer
C2 Cardholder ID (NCPDP D.0)	Insurance ID assigned to the cardholder or identification number used by the plan
N5 Medicaid ID Number (NCPDP D.0)	A unique member identification number assigned by the Medicaid Agency
N6 Medicaid Agency Number (NCPDP D.0)	Number assigned by processor to identify the individual Medicaid Agency or representative

Response COB/Other Payers Segment - 28 (NCPDP D.0)

NT Other Payor Id Count	Count of other payers with payment responsibility
5C Coverage Type	Code identifying the type of Other Payer ID
6C ID Qualifier	Code qualifying the Other Payer ID
7C ID	ID assigned to the payer
MH Process Control Number	Processor control number A number that uniquely identifies the secondary, tertiary, etc. payer to the processor
NU Cardholder ID	Cardholder ID for this member that is associated with the Payer noted
MJ Group ID	ID assigned to the cardholder group or employer group by the secondary, tertiary, etc. payer
UV Person Code	Code assigned by the other payer to a specific person within a family
UB Help Desk Number	Phone number of the other payer's help desk
UW Patient Relationship Code	Code assigned by the other payer to indicate the relationship of patient to cardholder
UX Benefit Effective Date	Other Payer's effective date of the patient's benefit
UY Benefit Termination Date	Other Payer's termination date of the patient's benefit

Response Patient Segment - 29

CA Patient First Name (NCPDP D.0)	Patient's first name
CB Patient Last Name (NCPDP D.0)	Patient's last name
CA Date of Birth (NCPDP D.0)	Patient's date of birth

Claim Transmit Detail Window - Page 1

To access page 1 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 1**.

The following describes the fields on page 1 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

Header Segment

A1 BIN Number	Third party BIN number
A2 Version Number	NCPDP version number **51** = version 5.1 **D0** = version D.0
A3 Transaction Code	Code that indicates the type of transaction **B1** = Billing **B2** = Reversal **B3** = Rebill **P1** = Prior Authorization Request and Billing **P2** = Prior Authorization Reversal **P3** = Prior Authorization Inquiry **P4** = Prior Authorization Request Only **N1** = Information Reporting **N2** = Information Reporting Reversal **N3** = Information Reporting Rebill **C1** = Controlled Substance Reporting **C2** = Controlled Substance Reporting Reversal **C3** = Controlled Substance Reporting Rebill
A4 Processor Number	Third party processor control number
B2 Provider ID Qualifier	NCPDP service provider ID qualifier Blank = Not Specified **01** = National Provider Identifier (NPI) **02** = Blue Cross **03** = Blue Shield **04** = Medicare **05** = Medicaid **06** = UPIN **07** = NCPDP Provider ID

	08 = State License **09** = Champus **10** = Health Industry Number (HIN) **11** = Federal Tax ID **12** = Drug Enforcement Administration (DEA) **13** = State Issued **14** = Plan Specific **99** = Other
B1 Provider ID	Service provider ID assigned by the third party
D1 Fill Date	Date the prescription was filled
AK Software Cert. ID	Software certification ID number

Patient Segment - 01

CA First Name	Patient's first name
CB Last Name	Patient's last name
CM Street Address	Patient's street address
CN City	City where the patient's address is located
CO State	State where the patient's address is located
CP ZIP Code	Patient's ZIP code
CQ Phone Number	Patient's phone number
C4 Date of Birth	Patient's date of birth
C5 Gender	Patient's gender **0** = Not specified **1** = Male **2** = Female
C7 Patient Location (NCPDP 5.1)	Type of residence where the patient lives (from the **Patient Location** field on the Patient Third Party window) **0** = Not specified **1** = Home **2** = Intemediate-Care **3** = Nursing Home **4** = Long Term/Extended Care

	5 = Rest Home **6** = Boarding Home **7** = Skilled Care Facility **8** = Sub-Acute Care Facility **9** = Acute Care Facility **10** = Outpatient **11** = Hospice **12** = End Stage Renal Disease Treatment Facility
C7 Place of Service (NCPDP D.0)	Code identifying the place where a drug or service is dispensed or administered.
CX Patient ID Qualifier	NCPDP patient ID qualifier
CY Patient ID	Patient ID number assigned by the third party
CZ Employer ID	Employer identification number for the patient's employer
1C Smoker Code	Code that indicates whether the patient is a smoker
2C Pregnancy Indicator	Code that indicates whether the patient is pregnant
4X Patient Residence	Code identifying the patient’s place of residence. **0** = Not specified **1** = Home **2** = Skilled Nursing Facility **3** = Nursing Facility **4** = Assisted Living Facility **5** = Custodial Care Facility **6** = Group Home **7** = Inpatient Psychiatric Facility **8** = Psychiatric Facility **9** = Intermediate Care Facility **10** = Residential Substance Abuse Treatment Facility **11** = Hospice **12** = Psychiatric Residential Treatment Facility **13** = Comprehensive Inpatient Rehabilitation Facility **14** = Homeless Shelter **15** = Correctional Institution
HN Patient Email	Email address of the patient (member)

Address

Claim Transmit Detail Window - Page 2

To access page 2 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 2**.

The following describes the fields on page 2 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

Pharmacy Provider Segment - 02

EY Provider ID Qualifier	Service provider ID qualifier Blank = Not Specified **01** = Drug Enforcement Administration **02** = State License **03** = Social Security Number **04** = Name **05** = National Provider Identifier (NPI) **06** = Health Industry Number (HIN) **07** = State Issued **99** = Other
E9 Provider ID	Pharmacy provider ID number

Prescriber Segment - 03

Primary Care

4E Provider Last Name	Last name of the primary care provider
2E Provider ID Qualifier	NCPDP ID qualifier of the primary care provider Blank = Not Specified **01** = National Provider Identifier (NPI) **02** = Blue Cross **03** = Blue Shield **04** = Medicare **05** = Medicaid **06** = UPIN **07** = NCPDP Provider ID **08** = State License **09** = Champus **10** = Health Industry Number (HIN) **11** = Federal Tax ID

	12 = Drug Enforcement Administration (DEA) **13** = State Issued **14** = Plan Specific **16** = CMEA Certificate ID **17** = Foreign Prescriber ID **99** = Other
DL Provider ID	Prescriber ID number assigned by the third party to the primary care prescriber
H5 Provider Location	Location address code assigned to the primary care prescriber by the National Provider System (NPS)

Prescriber Clinic

2K Prescriber Street Address	Free form text for prescriber address information
2M Prescriber City	Free form text for prescriber city name
2N Prescriber State	Standard state/province code as defined by appropriate government agency
2P Prescriber ZIP Code	Code defining international postal zone excluding punctuation and blanks

Prescriber Segment - 03 (cont.)

DR Prescriber Last Name	Prescriber's last name
2J Prescriber First Name	Individual's first name.
EZ ID Qualifier	NCPDP prescriber ID qualifier Blank = Not Specified **01** = National Provider Identifier (NPI) **02** = Blue Cross **03** = Blue Shield **04** = Medicare **05** = Medicaid **06** = UPIN **07** = NCPDP Provider ID **08** = State License **09** = Champus

	10 = Health Industry Number (HIN) **11** = Federal Tax ID **12** = Drug Enforcement Administration (DEA) **13** = State Issued **14** = Plan Specific **16** = CMEA Certificate ID **17** = Foreign Prescriber ID **99** = Other
DB Prescriber ID	Prescriber ID number assigned by the third party
1E Location Code	Location address code assigned to the prescriber by the National Provider System (NPS)
PM Phone Number	Prescriber's phone number

Insurance Segment - 04

C2 Cardholder ID	Cardholder identification number
CC Card First Name	First name of cardholder
CD Card Last Name	Last name of cardholder
C3 Person Code	Patient child or person number
C6 Relationship Code	Patient's relationship to the cardholder **0** = Not Specified **1** = Cardholder **2** = Spouse **3** = Child **4** = Other
C9 Eligibility Override	Indicates a patient who would not normally be covered is covered and why the person is covered Options include: **Not Specified**, **No Override**, **Override**, **Full-time Student**, **Disabled Dependent**, **Dependent Parent**, **Significant Other**, or **Employed**
CE Home Plan	Code that identifies the Blue Cross or Blue Shield plan ID, which indicates where the patient's coverage is designated **Note**: Blue Cross codes are less than 600 and Blue Shield codes are greater than 599.

FO Plan ID	ID number assigned by the processor to identify a set of parameters, benefit, or coverage criteria used to adjudicate the claim
C1 Group ID	ID number assigned to the cardholder group or employer group
8C Facility ID	ID number assigned to the patient's clinic
2A Medigap ID	Patient’s ID assigned by the Medigap Insurer
2B Medicaid Indicator	Two character state postal code indicating the state where Medicaid coverage exists
2D Accepts Assignment	Code indicating whether the provider accepts assignment
G2 CMS Facility	Indicates if the patient resides in a facility that qualifies for the CMS Part D benefit **Y** = resides in a CMS-qualified facility **N** = does not reside in a CMS-qualified facility
N5 Medicaid ID Number	Unique member identification number assigned by the Medicaid agency

Claim Transmit Detail Window - Page 3

On the Claim Transmit Detail – Page 3 window, you can transmit other payor rejected claim information for up to three third parties when rebilling a claim to a fourth third party. When you fill prescriptions for a patient with a fourth third party that requires you to send the other payor information for the previous third parties from which you received a rejection during claim adjudication (for example, Medicaid of Ohio), you can enter the payor information in the Other Payor 1, Other Payor 2, and Other Payor 3 sections for transmission to the fourth third party.

To access page 3 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 3**.

The following describes the fields on page 3 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription

Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number
Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

CoB/Other Payment Segment - 05

4C Other Payment Count	Number of other payers for the claim **0** = only the primary payer

Other Payer 1-9

5C Coverage Type	NCPDP other payer coverage type **Blank** = Not Specified **01** = Primary - First **02** = Secondary - Second **03** = Tertiary - Third **04** = Quaternary - Fourth **05** = Quinary - Fifth **06** = Senary - Sixth **07** = Septenary - Seventh **08** = Octonary - Eighth **09** = Nonary - Ninth
6C Payer ID Qualifier	NCPDP insurance ID qualifier **01** = National Payer ID **02** = Health Industry Number (HIN) **03** = Bank Information Number (BIN)

	04 = National Association of Insurance Commissioners (NAIC) **05** = Medicare Carrier Number **99** = Other
7C Payer ID	NCPDP other payer ID
E8 Payer Date	Date other coverage was paid
HB Amount Paid Count	Number of NCPDP other payer amount occurrences
DV and HC Amount/Qualifier	**Amount Paid** - Amount of any payment known by the pharmacy from other sources. **Qualifier** - NCPDP other payer amount paid qualifier **Blank** = Not Specified **01** = Delivery Cost **02** = Shipping Cost **03** = Postage Cost **04** = Administrative Cost **05** = Incentive Cost **06** = Cognitive Service Cost **07** = Drug Benefit Cost **09** = Compound Preparation Time option. (For details on these billing methods, see About COB Billing.)
NR Patient Responsibility Amount Count	Number of **Other Payer-Patient Responsibility Amount** (**NQ**) and **Other Payer-Patient Responsibility Amount Qualifier** (**NP**) occurrences.
NQ and NP Amount/Qualifier	**Amount Paid** - The patient's cost share from a previous payer **Qualifier** - Code qualifying the **Other Payer-Patient Responsibility Amount** (**NQ**) These fields are filled only after a payer has approved the claim. They are used for Patient Responsibility Amount Only Billing and Medicaid Full Disclosure Billing. (For details on these billing methods, see About COB Billing.) **Blank** = Not specified **01 =** Amount Applied to Periodic Deductible (FH) as reported by previous payer **02 =** Amount Attributed to Product Selection/Brand Drug

(UK) as reported by previous payer

03 = Amount Attributed to Sales Tax (FN) as reported by previous payer
A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription

04 = Amount Exceeding Periodic Benefit Maximum (FK) as reported by previous payer
A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded

05 = Amount of Copay (FI) as reported by previous payer

06 = Patient Pay Amount (F5) as reported by previous payer
Note: EPS sends this qualifier if the previous payer returned only the total Patient Pay Amount (F5) from the Patient Pay Amount formula. If the previous payer returned individual fields, EPS sends NP plus appropriate qualifiers in this list.

07 = Amount of Coinsurance (4U) as reported by previous payer

08 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection (UM) as reported by previous payer

09 = Amount Attributed to Health Plan Assistance Amount (UD) as reported by previous payer

10 = Amount Attributed to Provider Network Selection (UJ) as reported by previous payer

11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer

12 = Amount Attributed to Coverage Gap (UP) that was to be collected from the patient due to a coverage gap as reported by previous payer

13 = Amount Attributed to Processor Fee (NZ) as reported by previous payer

MU Benefit Stage Count

Number of **Benefit Stage Amount** (**MW**) occurences

MW and MV Amount/Qualifier

Amount Paid - The amount of claim allocated to the Medicare stage identified by the **Benefit Stage Qualifier** (**MV**).

	Qualifier - Code qualifying **Benefit Stage Amount** (**MW**) **Blank** = Not specified **01 =** Deductible - The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer **02 =** Initial Benefit - The first monthly benefit, or the first monthly benefit following any break in participation **03 =** Coverage Gap - Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out- of-pocket paid for covered prescription drugs reaches a certain amount. **04 =** Catastrophic Coverage - When a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year.
5E Reject Count	Number of reject codes received from the other payer
6E Other Payer Reject Codes	Reject code(s) received from the other payer
Additional Payers	Select to display information for the next three payers (if applicable).
Previous Payers	Select to display information for the previous three payers (if applicable).

Claim Transmit Detail Window - Page 4

To access page 4 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 4**.

The following describes the fields on page 4 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

Workers' Compensation Segment - 06

DY Date of Injury	Date the patient was injured
CR Carrier ID	Third party carrier code of the employer's workers' compensation carrier
DZ Claim/Reference ID	Reference number that identifies the workers' compensation claim
TR Billing Entity Type Indic.	Identifies the entity submitting the billing transaction **00** = Provider Submitted-Pay to Provider

Employer Information

CF Employer Name	Name of the patient's employer
CG Street Address	Employer's address
CH City	City where the employer's address is located
CI State	State where the employer's address is located
CJ ZIP Code	Employer's ZIP code
CK Phone Number	Employer's ZIP phone number
CL Contact Name	Name of the person to contact at the employer's office

Claim Transmit Detail Window - Page 5

To access page 5 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 5**.

The following describes the fields on page 5 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

Claim Segment - 07

EM Rx/Service # Qual	NCPDP prescription/service ID qualifier **Blank** = Not specified **1** = Prescription Billing **2** = Service Billing
D2 Rx/Service Number	Prescription or professional services file reference number
E1 Product ID Qualifier	NCPDP product ID qualifier **Blank** = Use Drug's UPC flag, or default to 03 (NDC) **00** = Not Specified **01** = Universal Product Code (UPC) **02** = Health Related Item (HRI) **03** = National Drug Code (NDC) **04** = Universal Product Number (UPN) **05** = Department of Defense (DOD) **06** = Drug Use Review/Professional Phcy Serv (DUR/PPS) **07** = Common Procedure Terminology (CPT4) **08** = Common Procedure Terminology (CPT5) **09** = Health Care Financing Administration Common Procedural Coding System (HCPCS) **A** = Pharmacy Practice Activity Classification (PPAC) **B** = National Pharmaceutical Prod Interface Cd (NAPPI) **C** = International Article Numbering System (EAN) **D** = Drug Identification Number (DIN)
D7 Product ID/NDC	NDC of the dispensed drug
ET Prescribed Quantity	Quantity prescribed for the prescription
E7 Quantity Dispensed	Quantity dispensed for the prescription

D5 Days' Supply	Days’ supply for the prescription
DF Refills Authorized	Number of refills authorized for the prescription
D3 Fill Number	Fill number of the prescription **0** = initial fill **1**= first refill, and so on
D8 DAW Code	Dispense as written code for the prescription **0** = No Selection Indicated **1** = Dispense as Written **2** = Brand: Patient Choice **3** = Brand: Pharmacist Choice **4** = Brand: Generic Out of Stock **5** = Brand Dispensed as Generic **6** = Override **7** = Brand: Mandated by Law **8** = Brand: Generic Unavailable **9** = Other
DE Rx Written Date	Date the prescription was written
DJ Rx Origin	Code that indicates the origin of the prescription **0** = Not Specified **1** = Written **2** = Telephone **3** = Electronic **4** = Fax
NX Sub Clarification Count	Number of **Submission Clarification** (**DK**) occurrences
DK Sub Clarification	Code that indicates that the pharmacist is clarifying the submission **1** = No Override **2** = Other Override **3** = Vacation Supply - indicates that the patient requested a vacation supply of the medication **4** = Lost Prescription - indicates that the patient requested a replacement of medication that was lost

5 = Therapy Change - indicates that the prescriber has determined that a change in therapy was required

6 = Starter Dose - indicates that the previous medication was a starter dose and now additional medication is needed to continue treatment

7 = Medically Necessary - indicates that the prescriber has determined that the medication is medically necessary

8 = Process Compound for Approved Ingredients

9 = Encounters

10 = Meet Plan Limitations - certifies that the transaction is in compliance with the program's policies and rules specific to the product being billed (NCPDP D.0)

11 = Certification on File - the supplier's guarantee that a copy of the paper certification, signed and dated by the physician, is on file at the supplier's office (NCPDP D.0)

12 = DME Replacement Indicator - indicates that this certification is for a DME item replacing a previously purchased DME item (NCPDP D.0)

13 = Payer-Recognized Emergency/Disaster Assistance Request - indicates that an override is needed based on an emergency/disaster situation recognized by the payer (NCPDP D.0)

14 = Long Term Care Leave of Absence - indicates that the cardholder requires a short-fill of a prescription due to a leave of absence from the Long Term Care (LTC) facility (NCPDP D.0)

15 = Long Term Care Replacement Medication - medication has been contaminated during administration in a long- term care setting (NCPDP D.0)

16 = Long Term Care Emergency box (kit) or automated dispensing machine - indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours (NCPDP D.0)

17 = Long Term Care Emergency supply remainder - indicates that the transaction is for the remainder of the drug originally begun from an emergency kit (NCPDP D.0)

18 = Long Term Care Patient Admit/Readmit Indicator - indicates that the transaction is for a new dispensing of medication due to the patient's admission or readmission status (NCPDP D.0)

19 = Split Billing - indicates the quantity dispensed is the

remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings. (NCPDP D.0)

20 = 34ØB - indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 34ØB of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). (NCPDP D.0)

99 = Other

C8 Other Coverage Code

NCPDP coverage code to indicate the type of coverage from another payer

Ø = Not specified

1 = No other coverage

2 = Other coverage exists, payment collected

3 = Other coverage billed, claim not covered

4 = Other coverage exists, payment not collected

8 = Claim is a billing for patient financial responsibility

NV Delay Reason Code

Code to specify the reason that submission of the transactions has been delayed

1 = Proof of eligibility unknown or unavailable

2 = Litigation

3 = Authorization delays

4 = Delay in certifying provider

5 = Delay in supplying billing forms

6 = Delay in delivery of custom-made appliances

7 = Third party processing delay

8 = Delay in eligibility determination

9 = Original claims rejected or denied due to a reason unrelated to the billing limitation rules

10 = Administration delay in the prior approval process

11 = Other

12 = Received late with no exceptions

13 = Substantial damage by fire, etc to provider records

14 = Theft, sabotage/other willful acts by employee

MT Patient Assign. Indicator

Code to indicate a patient’s choice on assignment of benefits to another party

	Y = Patient assigns benefits **N** = Patient does not assign benefits
E2 Route of Admin.	Override to the “default” route referenced for the product For a multi-ingredient compound, it is the route of the complete compound mixture.
G1 Compound Type	Identifies the type of compound **1** = Anti-infective - a medicinal product intended to treat pathogens such as bacteria, viruses, fungi or parasites **2** = Inotropic - a medicinal product intended to correct irregular heart rhythms **3** = Chemotherapy - a medicinal product intended to treat cancer **4** = Pain management - a regimen of therapy intended to ameliorate mild to severe discomfort **5** = TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition - products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts **6** = Hydration - a product intended to restore body fluids **7** = Ophthalmic - a product intended to be applied to or instill in the surface of the eye **99** = Other
U7 Pharmacy Service Type	Type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed **1** = Community/Retail Pharmacy Services **2** = Compounding Pharmacy Services **3** = Home Infusion Therapy Provider Services **4** = Institutional Pharmacy Services **5** = Long Term Care Pharmacy Services **6** = Mail Order Pharmacy Services **7** = Managed Care Organization Pharmacy Services **8** = Specialty Care Pharmacy Services **99** = Other
CW Alternate ID	Person identifier used for controlled substance reporting
EK Scheduled Rx ID	Serial number of the prescription blank/form
28 Unit of Measure	NCPDP standard unit of measure code

	EA = Each **GM** = Grams **ML** = Milliliters
DI Level of Service	NCPDP level of service code that indicates the level of service the pharmacist performed **0** = Not Specified **1** = Patient Consultation **2** = Home Delivery **3** = Emergency **4** = 24-Hour Service **5** = Patient Consultation Regarding Generic Product Selection **6** = In-Home Service
HD Dispensing Status	Code that indicates that the quantity dispensed is a partial fill or the completion of a partial fill **P** = Partial Fill **C** = Completion of Partial Fill
D6 Compound Code	Code that indicates whether the prescription is a compound **0** = Not Specified **1** = Not Compound **2** = Compound
DT Unit Dose Indicator	Code that indicates the type of unit dose dispensing **0** = Not specified **1** = Not Unit Dose **2** = Manufacturer Unit Dose **3** = Pharmacy Unit Dose

Associated Prescription

EN A Rx/Service # Qual	NCPDP prescription/service ID qualifier **Blank** = Not specified **1** = Prescription Billing **2** = Service Billing
EP A Rx/Service Number	Professional services file reference number

Prior Authorization

EU Prior Auth	Code that identifies the type of prior authorization

Type	**0** = Not specified **1** = Prior Authorization **2** - Medical Certification **3** - EPSDT (Early Periodic Screening Diagnosis Treatment) **4** - Exemption from Copay and/or Coinsurance **5** - Exemption from Rx **6** - Family Planning Indicator **7** - TANF (Temporary Assistance for Needy Families) **8** - Payer Defined Exemption **9** - Emergency Preparedness
EV Prior Auth Number	Prior authorization number

Intermediary Authorization

EW Inter Auth Type	Code that indicates the intermediary authorization type **Blank** or **Ø** = Not Specified **01** = Intermediary Authorization **99** = Other Override
EX Inter Authorization	NCPDP value indicating that intermediary authorization occurred

Originally Prescribed Info (for Credit Returns)

EJ O Rx/Service # Qual.	NCPDP prescription/service ID qualifier **Blank** = Not specified **1** = Prescription Billing **2** = Service Billing
EA O Rx/Service Number	Prescription or professional services file reference number
EB O Prescribed Quant.	Originally prescribed quantity Note: The system does not transmit this field when you use claim format P5N. You must create a custom claim format to include this field in transmissions to your state agency or third party.

Intended Fill Information

HF Intended Quantity	Originally intended quantity for a partial fill prescription (applicable if the **Dispensing Status** field contains a **P** or **C**)

HG Int Days' Supply	Days' supply based on the intended quantity for a partial fill prescription (applicable if the **Dispensing Status** field contains a **P** or **C**)

Claim Transmit Detail Window - Page 6

To access page 6 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 6**.

The following describes the fields on page 6 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

DUR/PPS Segment - 08

7E DUR/PPS Counter	Total number of DUR/PPS fields DUR/PPS fields include **E4-Reason for Service Code**, **E5-Professional Service Code**, **E6-Result of Service Code**, **8E-DUR/PPS Level of Effort Code**, **9E-DUR Co-Agent ID Qualifier**, and **H6-DUR Co-Agent ID**.

Coupon Segment - 09

KE Coupon Type	Code that indicates the type of coupon used for the claim **Blank** = Not Specified **01** = Price Discount **02** = Free Product **99** = Other
ME Coupon Number	Identification number of the coupon
NE Coupon Value	Dollar amount of the coupon

Compound Segment - 10

EF Dosage Form	NCPDP code for the unit of measurement of the compound **1** = Each **2** = Grams **3** = Milliliters
EG Dispensing Unit Form	NCPDP code for the unit in which the compound is dispensed **Blank** = Not Specified **01** = Capsule **02** = Ointment **03** = Cream **04** = Suppository **05** = Powder **06** = Emulsion

	07 = Liquid **10** = Tablet **11** = Solution **12** = Suspension **13** = Lotion **14** = Shampoo **15** = Elixir **16** = Syrup **17** = Lozenge **18** = Enema
EH Route of Administr.	NCPDP code for the route of administration of the compound 0 = Not Specified 1 = Buccal 2 = Dental 3 = Inhalation 4 = Injection 5 = Intraperitoneal 6 = Irrigation 7 = Mouth/Throat 8 = Mucous Membrane 9 = Nasal 10 = Ophthalmic 11 = Oral 12 = Other/Miscellaneous 13 = Otic 14 = Perfusion 15 = Rectal 16 = Sublingual 17 = Topical 18 = Transdermal 19 = Translingual 20 = Urethral 21 = Vaginal 22 = Enteral
EC Ingredient Count	Number of ingredients in the compound

The system displays information in the following table only for compound prescriptions

RE Product ID Qualifier	Code qualifying the type of product dispensed
TE Product ID	Product identifier for an ingredient used in a compound
ED Quantity	Amount expressed in metric decimal units of the product included in the compound
EE Drug Cost	Ingredient cost for the metric decimal quantity of the product included in the compound indicated in **ED Quantity**
UE Cost Determination Basis	Code that indicates how the **EE Drug Cost** field was calculated **Blank, 00** = Not Specified **01** = AWP (Average Wholesale Price) **02** = Local Wholesaler **03** = Direct **04** = EAC (Estimated Acquisition Cost) **05** = Acquisition Cost **06** = MAC (Maximum Allowable Cost) **07** = Usual and Customary Cost **08** = 34ØB /Disproportionate Share Pricing/Public Health Service **09** = Other **10** = ASP (Average Sales Price) **11** = AMP (Average Manufacturer Price) **12** = WAC (Wholesale Acquisition Cost) **13** = Special Patient Pricing
2H Modifier Code(s)	Identifies special circumstances related to the dispensing/payment of the product as identified in the **TE Product ID**

Claim Transmit Detail Window - Page 7

To access page 7 of the Claim Transmit Detail window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Transmit Detail**.
4. On the Claim Transmit Detail window, select **Page 7**.

The following describes the fields on page 7 of the Claim Transmit Detail window.

KP Rx	Standard prescription number for the order This number is unique not just at the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescriber changes. If any one of these changes, a new KP Rx number is generated. If the prescriber authorizes refills and does not change one of these values, the KP Rx does **not** change.
Patient	Patient for whom the prescription was filled
MRN	Patient's local or home medical record number
Status	Current status of the claim
Tx Number	Transaction number associated with the claim
Drug	Drug used to fill the prescription
Paid	Payment status of the claim
Reference #	Reference number returned by the processor for the claim
Carrier ID	Carrier identification code
Fill Date	Date you filled the prescription
Quantity	Quantity dispensed for the prescription
Type	Claim format code (entered in the **Claim Format Code** field on the Insurance Plan Transmit window)
Plan ID	Unique plan number

Plan Name	Name of the insurance carrier
View Transmit File	Select to view the file that was transmitted to the third party. The system displays the View Transmit File window with the claim data in its raw format. Select **Print** to print the claim data to your designated printer.

Pricing Segment - 11

DQ U & C Charge	Price of a cash prescription excluding sales tax and other amounts claimed
DU Gross Amount Due	Total price of the prescription
DN Basis of Cost Determ	Code that indicates how the **D9-Ingredient Cost** field was calculated **Blank** = Not Specified **00** = Not Specified **01** = AWP (Average Wholesale Price) **02** = Local Wholesaler **03** = Direct **04** = EAC (Estimated Acquisition Cost) **05** = Acquisition Cost **06** = MAC (Maximum Allowable Cost) **07** = Usual and Customary Cost **09** = Other

Submitted Amounts

D9 Ingredient Cost	Submitted product component cost for the prescription
DC Dispensing Fee	Dispensing fee charged for the prescription
BE Prof Service Fee	Professional services fee charged for the prescription
DX Patient Paid	Amount the patient paid
E3 Incentive	Amount submitted for a contractually agreed upon service
HA Flat Sales Tax	Dollar amount of sales tax paid
GE % Sales Amount	Percentage sales tax submitted
HE % Sales Tax	Percentage sales tax rate used to calculate the **GE % Sales**

Rate	**Amount** field
JE % Sales Tax Basis	Code that indicates the basis for percentage sales tax Blank = Not Specified **01** = Gross Amount Due **02** = Ingredient Cost **03** = Ingredient Cost + Dispensing Fee
H7 Other Amount Count	Total number of other amount claimed submitted fields (includes **H8-Other Amount Claimed Submitted Qualifier** and **H9-Other Amount Claimed Submitted**)
H9 and H8 Other Amount Claimed/Qualifier	**Other Amount Claimed Submitted** - Amount representing the additional incurred costs for a dispensed prescription or service **Other Amount Claimed Submitted Qualifier** - Code identifying the additional incurred cost claimed in **Other Amount Claimed Submitted** Blank = Not specified **01** = Delivery Cost **02** = Shipping Cost **03** = Postage Cost **04** = Administrative Cost **99** = Other

Clinical Segment - 13

VE Diagnosis Code Count	Number of diagnosis code occurrences
WE Code Qualifier	Code qualifying the **Diagnosis Code** (**DO**)
DO Diagnosis Code	Code identifying the diagnosis of the patient

Pricing Information Window

To access the Pricing Information window:

1. Select **Tools > TP Transmit Queue**.
2. Set the **Status** and select **Refresh**.
3. Select a TP claim record, then select **View Pricing Detail**.

The following describes the fields on the Pricing Information window.

Rx Number	Prescription number associated with the claim
Tx Number	Transaction number associated with the claim
Reference #	Reference number returned by the processor for the claim
Patient	Patient for whom the prescription was filled
Drug	Drug used to fill the prescription
Plan Name	Name of the insurance plan to which the claim was billed
Amount Submitted	Cost of the prescription submitted to the third party
Amount Final	Final cost after adjudication
Copay Submitted	Copay amount submitted to the third party
Copay Final	Final copay after adjudication
ACQ	Base cost of the prescription
Cost Base Used	Cost base (from the drug file) to calculate third party price: **ACQ-Acquisition Cost**, **AWP-Average Wholesale Price**, **MAC-Maximum Allowable Cost**, **REG-Regular Cost**, **STD-Standard Cost**, **WEL-Welfare Cost** (Apply fee and subtract copay from this cost base to calculate third party price.) **Blank** = cost base is set on the price code—you used a price code to price the third party
Unbalanced Pricing Segment	Indicates if the third party returned values in the Pricing segment do not balance with the NCPDP pricing formula: Ingredient Cost Paid (506-F6) + Dispensing Fee Paid (507-F7)

	+ Incentive Amount Paid (521-FL) + Other Amount Paid (565-J4) + Flat Sales Tax Amount Paid (558-AW) + Percentage Sales Tax Amount Paid (559-AX) - Patient Pay Amount (505-F5) - Other Payer Amount Recognized (566-J5) ---------- = Total Amount Paid (509-F9) **Yes** = values balance with the NCPDP pricing formula The system continues adjudication as usual. **No** = values do not balance with the NCPDP pricing formula The system sets the **Unbalanced Pricing Segment** flag to **Yes**, allows you to complete claim adjudication as normal, and displays the following note as a This Fill note where applicable when you continue processing the task (for example, RPh/Data Verification and Will Call): **The Pricing segment received in the third party's response does not balance to the NCPDP Pricing Formula. Contact the TP administrator to resolve this issue.** **Note**: If a help desk number is available, the system also displays **Help desk number for this plan is** [*phone number*] with the This Fill note.
TP Balance	Amount paid by the third party
% Gross M	Percentage gross profit for the prescription
$ Gross M	Gross profit dollar amount for the prescription
View Details	Select to view additional claim pricing information.
OK	Select to return to the Third Party Transmit Queue window.