Third Party Exceptions Overview

From the Third Party Exception windows, you can review any third party adjudication exceptions, such as rejects, low pays, DURs, and so forth, and correct information as needed so you can try to retransmit the claim.
About COB Billing

EPS uses three types of billing during Coordination of Benefits processing:

- **Other Payer Amount Paid Billing**
  With this method, EPS sends an **Other Coverage Code** of 2 *(Payment Collected)* or 4 *(Payment Not Collected)* in the Claim Segment. The system also sends the **Other Payer Amount Paid** with applicable qualifiers in the COB Segment.

- **Patient Responsibility Amount Only** *(called Copay-Only Billing in NCPDP 5.1)*
  With this method, EPS sends an **Other Coverage Code** of 8 *(Claim is For Copay)* in the Claim Segment. The system also sends the **Other Payer Patient Responsibility Amount** with applicable qualifier(s) in the COB Segment *(this is new for NCPDP D.0)*.

- **Government Full Disclosure Billing**
  With this method, EPS sends **Other Coverage Code** of 2 *(Payment Collected)* or 4 *(Payment Not Collected)* in the Claim Segment. This method combines the previous two methods by sending both the **Other Payer Amount Paid** with applicable qualifier(s) AND **Other Payer Patient Responsibility Amount** with applicable qualifier(s) in the COB Segment. *(Sending the **Other Payer Patient Responsibility Amount** and qualifiers is new for NCPDP D.0)*.
Other Payer Amount Paid COB Billing

In Other Payer Amount Paid Billing, EPS calculates the Other Payer Amount Paid (Drug Benefit) from the payer’s response. The calculation for this is:

\[
509-F9 \text{ Total Amount Paid} \\
- \text{ Total J4 and FL Other Amounts Paid (uniquely reported)} \\
= \text{ Total Drug Benefit (DV)}
\]

For example, assume a patient has four payers for a claim. The figures below show in a spreadsheet how EPS calculates these values.

Primary Payer

For the primary payer, EPS calculates the Other Amount Paid (Drug Benefit) as follows:
## Secondary Payer

To calculate the secondary payer's **509-F9 Total Amount Paid**, EPS adds all amounts in the COB Segment (the J4 and FL amounts) to determine the **566-J5 Other Payer Amount Recognized** (cell D40). Then the system adds all the other amounts paid (cells D32 through D37 below), and subtracts the primary payer's total amount paid and the **505-F5 Patient Pay Amount**.

Click [here](#) for an illustration of this calculation.

EPS then calculates the difference between the previous and the current payer's payments for each type of J4 payment (**Delivery**, **Shipping**, **Postage**, **Administrative**, **Compound Preparation**, or **Other**) and for the **FL Incentive Amount Paid**. In this example, the

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>506-F6 Ingredient Cost Paid</td>
<td>$90.00</td>
</tr>
<tr>
<td>3</td>
<td>507-F7 Dispensing Fee Paid</td>
<td>$3.00</td>
</tr>
<tr>
<td>4</td>
<td>565-J4 Other Amount Paid (Delivery)</td>
<td>$10.00</td>
</tr>
<tr>
<td>5</td>
<td>565-J4 Other Amount Paid (Compound)</td>
<td>$6.00</td>
</tr>
<tr>
<td>6</td>
<td>521-FL Incentive Amount Paid</td>
<td>$4.00</td>
</tr>
<tr>
<td>7</td>
<td>559-AX Percentage Sales Tax Amount Paid</td>
<td>$4.50</td>
</tr>
<tr>
<td>8</td>
<td>561-AZ Percentage Sales Tax Basis Paid</td>
<td>0.52-cost</td>
</tr>
<tr>
<td>9</td>
<td>569-AI Percentage Sales Tax Rate Paid</td>
<td>0.05</td>
</tr>
<tr>
<td>10</td>
<td>505-F5 Patient Pay Amount</td>
<td>$20.00</td>
</tr>
<tr>
<td>11</td>
<td>509-F9 Total Amount Paid</td>
<td>$97.50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Request Pricing Segment Sent to Secondary</td>
</tr>
<tr>
<td>13</td>
<td>409-D0 Ingredient Cost Submitted</td>
</tr>
<tr>
<td>14</td>
<td>412-GG Dispensing Fee Submitted</td>
</tr>
<tr>
<td>15</td>
<td>480-H9 Other Amt Claimed Submitted (Delivery)</td>
</tr>
<tr>
<td>16</td>
<td>480-H9 Other Amt Claimed Submitted (Compound)</td>
</tr>
<tr>
<td>17</td>
<td>438-E3 Incentive Amount Submitted</td>
</tr>
<tr>
<td>18</td>
<td>Percent Sales Tax Amount</td>
</tr>
<tr>
<td>19</td>
<td>Percentage Sales Tax Basis</td>
</tr>
<tr>
<td>20</td>
<td>Percentage Sales Tax Rate</td>
</tr>
<tr>
<td>21</td>
<td>430-DU Gross Amount Due</td>
</tr>
<tr>
<td>22</td>
<td>426-DQ Usual and Customary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>COB Segment</td>
</tr>
<tr>
<td>24</td>
<td>565-J4 Other Amount Paid (Delivery)</td>
</tr>
<tr>
<td>25</td>
<td>565-J4 Other Amount Paid (Compound)</td>
</tr>
<tr>
<td>26</td>
<td>521-FL Incentive Amount Paid</td>
</tr>
<tr>
<td>27</td>
<td>565-J4 Other Amount Paid (Sales Tax)</td>
</tr>
<tr>
<td>28</td>
<td>565-J4 Other Amount Paid (Drug Benefit)</td>
</tr>
</tbody>
</table>
pharmacy submitted only two types of J4 amounts: Delivery ($12.00) and Compound Preparation ($9.00).

**Tertiary Payer**

For the tertiary payer, the system continues this process, except it now has two previous payers to consider. EPS adds all amounts shown in bold red in the figure below and displays the amount in **Other Payer Amt Recognized** (cell E71). The Incentive Fee is not contracted, therefore cells C57 and D57 are not included in the calculation.

Click [here](#) for an illustration of this calculation.

**Quaternary Payer**

Once again, for the final payer, the system continues this process, except it now has three previous payers to consider. EPS adds all amounts shown in bold red in the figure below and displays the amount in **Other Payer Amt Recognized** (cell G101). In this case, neither the Delivery Fee or Incentive Fee are contracted, therefore cells C86, D86, and E86 (for Delivery) and C88, D88 and E88 (for Incentive) are not included in the calculation.

Click [here](#) for an illustration of this calculation.
Other Payer Patient Responsibility Amount Only Billing

For COB processing based on Other Payer Patient Responsibility Amounts, the net amount due is the sum of the payable components of the Other Payer Patient Responsibility values from

- the LAST payer
- as determined by 338-5C Other Coverage Type (Primary, Secondary, and so on)
- that returned a PAID response

When reimbursement is based on the Other Payer Patient Responsibility Amount, EPS returns a Basis of Reimbursement Code (522-FM) of 14.

The payer's response returns these fields (NP = Amount Paid Qualifier, NQ = Amount Paid):

- NP=01  NQ from 517-FH Amount Applied to Periodic Deductible
- NP=02  NQ from 134-UK Amount Attributed to Product Selection/Brand Drug
- NP=03  NQ from 523-FN Amount Attributed to Sales Tax
- NP=04  NQ from 520-FK Amount Exceeding Periodic Benefit Maximum
- NP=05  NQ from 518-FI Amount of Copay
- NP=06  NQ from 505-F5 Patient Pay Amount
- NP=07  NQ from 572-4U Amount of Coinsurance
- NP=08  NQ from 135-UM Amount Attributed to Product Selection/Non-Preferred Formulary Selection
- NP=09  NQ from 129-UD Health Plan Funded Assistance Amount (always negative or zero)
• **NP=10**  **NQ** from 133-UJ *Amount Attributed to Provider Network Selection*

• **NP=11**  **NQ** from 136-UN *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection*

• **NP=12**  **NQ** from 137-UP *Amount Attributed to Coverage Gap*

• **NP=13**  **NQ** from 571-NZ *Amount Attributed to Processor Fee*

**Note:** If NP value 06 ([505-F5 Patient Pay Amount](#)) is submitted, EPS does not submit any other qualifiers or values.
Government Full Disclosure Billing

For COB processing based on the Government Full Disclosure Billing method, the system uses the Other Payer Amount Paid and Other Payer Patient Responsibility methods of billing. When processing using the Other Payer Amount Paid method, the system considers all of the COB other payer loops when adjudicating the claim. When processing using the Other Payer Patient Responsibility method, the system adjudicates the claim based on the patient responsibility amount(s) in field 352-NQ Other Payer-Patient Responsibility Amount from the last payer.

When legislation or regulation requires full disclosure, the provider must submit Other Payer Amounts Paid and Other Payer Patient Responsibility Amounts as reported from prior payers. EPS determines the value of the claim according to government agency rules. Other Payer Amounts Paid are summarized across payers by type. Other Payer Patient Responsibility Amounts are not summed between payers.
Correct Data From TP Exception

When you get a third party exception and can correct a data file to resolve the third party exception, use this procedure from the Third Party Exception window.

To correct data from the Third Party Exception window:

1. Select the button for the corresponding data file you need to correct. For example, to correct information in the patient third party record, select Patient TP.

   The system displays the corresponding data file window with the record related to this transaction.

2. On the data file window, change information as necessary and select Save.

3. If needed, select Back to Task to return to the Third Party Exception window.

4. Select Retransmit.

   The system does the following:
   - creates a new third party queue record and message
   - sends that message to the third party
   - refreshes the Third Party Exception window with the results of the transmission
Process Paid Claim

If you correct and retransmit the claim from the Third Party Exception window and the third party returns a status that it is paying or partially paying the claim, the system displays that information and places the cursor on the **Complete** button.

To continue processing this claim, select **Complete**.
Add Payments to a Claim

Sometimes you must manually add payments to a claim on the Coordination of Benefits Review window to get it to successfully complete the claims process.

To add payments:

1. If necessary, select Additional Payers to display the payer you want to update.

2. If necessary use the scroll bar to display the category of payments (Patient Responsibility Amounts or Benefit Stage Amounts).

3. Under the appropriate category (Other Payer Amounts Paid, Patient Responsibility Amounts, or Benefit Stage Amounts), select the Add Amount button under the list box.

4. Select the type of payment from the Qualifier drop-down list.

5. Double-click the area to the left of the Qualifier drop-down list.

6. Enter the amount and press Tab.

7. Add other payments (if needed) and select Complete.
Edit Billing Information

If you receive a Third Party Exception task and you need change the billing order or select different plans for a claim so you can retransmit it, do the following.

To edit billing information:

1. With the claim on the Third Party Exception window, select **Edit Billing**.

   Do one or more of the following, as needed.

   **Note:** The system allows you to change the billing options for unpaid portions of a claim only. For example, if the primary third party paid but the secondary rejected, the system disables the **Primary (1) Third Party** drop-down list.

   - To change the primary insurance plan, select the plan from the **Primary (1) Third Party** drop-down list.
   - To split bill to different insurance plans, select the plans to bill to from the drop-down lists. The system can display up to nine third parties.

2. Select **Save**.

   The system returns to the Third Party Exception window.

3. Change any additional information as needed.

4. Select **Retransmit**.

   The system does the following.

   - creates a new TP Transmit Queue record and message
   - sends that message to the third party/parties
   - refreshes the Third Party Exception window with the results
of the transmission

5. When you finish processing the task, select Complete.
Edit Third Party Information

If you receive a Third Party Exception task and you need to correct or add information required by the third party, use this procedure.

To correct third party information:

1. On the Third Party Exception window, select **Edit Tp Info**.

   The system displays the Edit TP Information window with the current claim's information. For more information, see [Edit TP Information Window](#).

2. Change information as necessary and select **Save**.

   The system returns to the Third Party Exception window.

3. Change any information as needed.

4. Select **Retransmit**.

   The system does the following.
   - creates a new TP Transmit Queue record and message
   - sends that message to the third party
   - refreshes the Third Party Exception window with the results of the transmission

5. When you finish processing the task, select **Complete**.
**Manually Update a Claim**

To manually update the payment information on a rejected claim for which you need to contact the third party to obtain verbal authorization, do the following.

**To manually update a claim:**

1. Select **Claim Override**.
   
   The system displays the Manual Claim Override window.

2. Update the payment information as needed.

3. Select **Save**.

4. Select **Close**.
   
   The system returns to the Third Party Exception window.

5. Select **Complete**.
   
   The system updates the claim information and enters **Transmit** in the **Submit Type** field on the Transaction Detail Third Party window.

**See Also**

Manual Claim Override window
Process Failed Reversal

If you receive a Third Party Exception task that was created as a result of a failed claim reversal during another process (for example, a credit return or billing change), the system displays the following message: *This prescription has been cancelled or credit returned. You may need to phone the third party to perform a reversal. Use Claim Override to update the claim prior to complete. Once this task is completed, this prescription will be removed from workflow.*

To process a Third Party Exception task for a failed reversal:

1. Select **Reverse**.

2. If the reversal is successful, go to step 7.

**Notes:**

- If the number of days in the **Reversal Days** field on the Insurance Plan Billing window has elapsed since the prescription was filled, the system prompts **Cannot Reverse Claim. Reversal is only allowed within [#] days. This claim was filled [#] days ago.** Go to step 3.

- If the reversal fails again, the system prompts **Reversal transmission failed. You may need to phone the third party to perform a manual reversal. Complete the task when finished.** Go to step 2.

3. Contact the third party, if needed, to manually reverse the claim.

4. Select **Claim Override**.

5. Enter the information as needed on the Claim Override window and select **Save**.

   For more information, see [Manual Claim Override window](#).

6. Select **Close** to return to the Third Party Exception window.
7. Select **Complete** to complete the task.
Print Notice of Appeal

When Medicare Part D either rejects a claim that was submitted as a Part D eligible medication or pays the claim but uses a benefit other than Medicare Part D, the patient is entitled to receive a Notice of Appeal and can appeal the denial of coverage by their Medicare Part D Plan. To help pharmacies accommodate this requirement, EPS provides application support to print a CMS Pharmacy Notice of Appeal Rights Document in the following instances:

- you receive a reject code of 569 in the 511-FB Reject Code and Occurrence Indic field of the claim
- you receive an approval code of 018 in the 548-6F Approved Message Codes field of the claim

**NOTE:** Until 1/1/2013, the plan should also return the Benefit Stage Qualifier (393-MV) value 60 with this Approved Message Code. On 1/1/2013 and beyond, the plan should return the Benefit Stage Qualifier (393-MV) values of 61 or 70, which are more specific, with this approved message code which are more specific.

**Notice:** Before using the Notice of Appeal form provided by PDX, each customer must review and verify that this form meets all legal requirements. **Customer assumes all responsibility for the content of this form** and by using the form provided by PDX, customer agrees to defend and hold harmless PDX, Inc. its parent, subsidiaries and affiliates and their employees, directors, officers, from any claims arising out of the use of this form.

**To print Notice of Appeal:**

EPS can print this Notice of Appeal document from various places throughout the system, depending on how you set up the system, the implementation you use (Workflow or RapidFill), and other factors.
• **Set to Auto-Print in Workflow**
  To set the system to automatically print the document from Workflow when you receive the 569 or 018 codes, set the **Medicare Rights Notice – CMS Letter Ready To Print After** drop-down list to **Data Verification, Fill, or Product Verification** on the Administration > Application Settings > Workflow Settings > Print Label window to indicate when you want the document to print. For example, if you select **Fill**, the system prints the document after the Fill station if it receives one of those codes for that claim.

• **Set to Auto-Print in RapidFill**
  To set the system to automatically print the document from RapidFill when you receive the 569 or 018 codes, set the **RPh Verification Labels– Printing Enabled** drop-down list on the Administration > Application Settings > Workflow Settings > Print Label window as indicated:

  Set it to **Yes** to print the document after RPh Verification when the system receives the 569 or 018 code.

  Set it to **No** to print the document after Data Entry when the system receives an approval code of 018 and to print the document after Third Party Exception when the system receives the reject code of 569.

• **Print from CMS Notice Window (Workflow and RapidFill)**
  If you receive the 569 or 018 codes on a Part D claim when you perform administrative rebilling, run downtime claim adjudication, or change filling for a transaction so that the system displays the Print CMS Notice window, select **Yes** to print the document to your reports printer.

  When the system prints the Notice of Appeal document, it selects and prints the drug name based on this hierarchy on the Drug Information
window: **Detailed Packaged Drug Description, Alternate NHIN Drug Name**, and then **Packaged Drug Name**.
Reject - Add Call Task

If you need additional information from the prescriber, patient, or insurance plan to complete a Third Party Exception task, you can reject the task and create a Call task. The system adds a record to the Open Calls queue and the staff member responsible for Call tasks can contact the prescriber, patient, or insurance plan.

**Note:** We recommend that you always try to contact the prescriber, patient, or insurance plan before you create a Call task.

**To reject a Third Party Exception task and add a Call task:**

1. Select **Reject** at the top of the Third Party Exception window.

   The system displays the Third Party Exception - Reject Options window.

2. Select **Need More Information**.

3. Select **Prescriber**, **Patient**, or **Insurance Plan** as needed.

   If you select **Prescriber**, the system displays the call schedule for the prescriber so you can change it if needed. You can select the **For Entire Clinic** option to change the schedule for the clinic or select the **For Individual Prescriber** option to change the schedule for the prescriber.

   For Mail to Patient refill orders only, if you selected **Patient**, the system displays the **Send OutBound Message** option and **Outbound Message Reason** drop-down list.

   To send a message to the patient:

   a. Select **Send OutBound Message**.

   b. Select the reason for the message from the **Outbound Message Reason** drop-down list.

4. If you called the prescriber, patient, or insurance plan and left a
message, select **Message Left**.

5. In the **Next Call Date and Time** fields, enter the date and time you want to schedule the Call task.

6. Enter the reason you are rejecting the task in the **Description** field.

7. Select **OK**.

   The system adds a record to the Open Call queue.

**See Also**

**Third Party - Reject Options Window**

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Reject - Cancel Prescription

If you attempt to cancel the completion fill of a prescription while the partial fill is still in workflow, the system displays: *If you cancel the Completion Fill transaction, the corresponding Partial Fill will also be canceled. Continue?*

To reject a Third Party Exception task and cancel the prescription:

1. Select **Reject** at the top of the Data Entry window.

   The system displays the Third Party Verification Exception - Reject Options window.

2. Select **Cancel This Prescription**.

   The system displays **Remove from workflow** under the reject options.

The system displays fields as shown in the following table.

<table>
<thead>
<tr>
<th>Type of prescription</th>
<th>Field Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>New prescriber-written</td>
<td>Cancel this fill and return hard copy</td>
</tr>
<tr>
<td>Multiple prescriptions written on the same hard copy</td>
<td>Cancel all Rx’s and return hard copy</td>
</tr>
<tr>
<td>New prescriptions not written by the prescriber (for example, eScript, phoned in, or faxed prescriptions)</td>
<td>Cancelled by Prescriber (this action deactivates the prescription)</td>
</tr>
<tr>
<td></td>
<td>Cancelled by Pharmacist (this action deactivates the prescription)</td>
</tr>
<tr>
<td>Refill</td>
<td>Cancel and leave the Rx active Cancel Reason Deactivate Reason</td>
</tr>
</tbody>
</table>

The system also displays the following fields:
The **Send Outbound Patient Message** checkbox and **Outbound Message Reason** drop-down list (for Mail to Patient orders only).

3. To send a message to the patient explaining the reason for the cancellation:
   
a. Select **Send Outbound Patient Message**.

   b. Select the reason from the **Outbound Message Reason** drop-down list.

   **Note:** If you select **Refill Too Soon** as the message reason, the system selects that for the **Cancel Reason** if you are cancelling the prescription but leaving the it active.

4. Select the appropriate option for the type of prescription you are cancelling.

   The system enables the cancellation/deactivation reasons if appropriate. When you select the appropriate reason, the system enters the corresponding text in the **Description** field. You can add to the text if needed.

5. In the **Description** field, type any additional text explaining the reason you are rejecting the task.

6. Select **OK**.

**See Also**

*Third Party - Reject Options Window*
Reject - Put Claim in Downtime

If the third party exception failed to transmit and you want to continue filling the prescription, you can put the claim in downtime to transmit later.

To put a claim on the Third Party Exception window in downtime:

1. Select **Reject** at the top of the Third Party Exception window.
   
   The system displays the Third Party Exception – Reject Options window.

2. Select **Put Claim in Downtime**.

3. Select **Continue Fill, Enter Copay**.
   
   **Note**: The **Copay** field cannot be edited, and the system defaults this field to **0.00**.

4. In the **Description** text box, enter a reason for putting the claim in downtime.

5. Select **OK**.
   
   The system adds a record to the Third Party Transmit queue with a status of **Downtime**.

See Also

**Third Party - Reject Options Window**
Reject - Return to Data Entry

If you cannot process a Third Party Exception task because a correction must be made at Data Entry, you can reject the task and send it back to Data Entry.

**To reject a Third Party Exception task and send the task back to Data Entry:**

1. Select **Reject** at the top of the window.
   
The system displays the Third Party Exception – Reject Options window.

2. Select **Return to Data Entry for Correction**.

3. In the **Data Entry Error(s)** section, select the checkbox beside the appropriate options to indicate what needs to be corrected at Data Entry. For example, if a new drug is required, select the **Dispensed Drug** checkbox.

4. In the **Description** text box, enter any additional text to indicate the reason you are rejecting the Third Party Exception task.

5. Select **OK**.
   
The system creates a Data Entry Exception task.

**See Also**

[Third Party - Reject Options Window](#)
Reverse a Claim from TP Exception

To reverse a paid or partially paid claim:

1. With the paid, partially paid, or low pay claim on the Third Party Exception window, select **Reverse**.

   The system transmits a reversal request to the third party and displays the third party's response.

2. Do one of the following, as needed.
   - Correct the claim and retransmit it.

      For more information, see [Correct Data From TP Exception](#) or [Correct Claim Using Data Entry](#).
   - Change the billing sequence or select another third party.

      For more information, see [Edit Billing Information](#).
   - Fill the prescription as a cash prescription.

      For more information, see Fill As Cash.

3. Select **Complete**.
Troubleshoot TP Exception

To help you find the information causing the third party exception:

1. Do one or both of the following, as needed.
   - To access the third party's response to the claim, select Response Detail.
   - To access the information you transmitted to the third party, select Transmit Detail.
   - To display the prescription image or system-generated hard copy, select View Rx Image or press Alt + X.

2. Review the pages of information.

3. If you find an error you can correct, select Back to Task and then select the data record button or task button for the data you need to correct.

4. If you can correct the error, select Retransmit to retransmit the claim.

See Also

Claim Response Detail Window – Page 1
Claim Transmit Detail Window – Page 1
Coordination of Benefits Review Window

The system displays the Coordination of Benefits (CoB) Review window when you select **Next Task** and you are authorized to process Third Party Exception tasks. Your user role and workstation configuration determine if you can process these tasks. The system creates a CoB Review task when you receive a response from a primary or secondary third party and need to enter additional information to split bill the claim to the additional third parties.

**Notes:**

- The **Requires Split Bill Review** checkbox on the Insurance Plan Billing window determines if a plan requires you to enter additional information before submitting a split billed claim.

- You can also access this window by selecting the **Review CoB** button on the Third Party Exception window.

- Unless you have the proper user role, you can only select the **Other Coverage Code** and **ID Qualifier**, and enter an **ID**. All other fields are view only.

The following describes the fields on the CoB Review window.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
<td>Name of the patient for whom the prescription was filled</td>
</tr>
<tr>
<td><strong>Drug Name</strong></td>
<td>Drug name and strength of dispensed drug</td>
</tr>
<tr>
<td><strong>Fill Date</strong></td>
<td>Date the drug was entered to be filled</td>
</tr>
<tr>
<td><strong>Quantity</strong></td>
<td>Quantity to dispense for this fill</td>
</tr>
<tr>
<td><strong>Rx Number</strong></td>
<td>Prescription number</td>
</tr>
<tr>
<td><strong>Tx Number</strong></td>
<td>Transaction number</td>
</tr>
<tr>
<td><strong>Reference #</strong></td>
<td>Reference number from the third party (used in transmitting reversals)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Status of the transmittal: <strong>Not Specified, Waiting, Sending, Received, Complete, Send Credit, Credit, Downtime</strong></td>
</tr>
<tr>
<td><strong>Paid</strong></td>
<td>Paid status of the claim</td>
</tr>
</tbody>
</table>

**No payment status received** = third party has not paid
because the claim’s status is either **Waiting**, **Sending**, or **Send Credit**

**Paid** = third party received transmitted claim and paid in full

**Part Paid** = third party received transmitted claim and partially paid for the claim

**Rejected** = third party rejected the claim or reversal, or the transmission failed

**Credit** = third party accepted the claim reversal

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmittal code</td>
<td>Located in the <strong>Claim Format Code</strong> field on the Insurance Plan Transmit window for this plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coordination of Benefits</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table</td>
<td>Displays the patient's third parties and the status of the current claim for each third party (Lists up to nine third parties.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Coverage Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCPDP coverage code</td>
<td>Indicates the type of coverage from another payer</td>
</tr>
<tr>
<td>Blank or 0</td>
<td>Not specified by patient</td>
</tr>
</tbody>
</table>

**1 - No Other Coverage**

This value must only be submitted AFTER the provider has exhausted all means of determining pharmacy benefit coverage and no other coverage was identified.

**2 - Payment Collected**

Use this value when Total Amount Paid (F9) from a prior payer is more than zero.

**3 - This Claim Not Covered**

This value is filled when all previous payers reject the claim.

**4 - Payment Not Collected**

**5 - Mng Care Denial (5.1 Only)**

**6 - Non-Part Prov (5.1 Only)**

**7 - Cov Not In Effect (5.1 Only)**

**8 - Claim is For Copay**

Select to display information for the next three payers (if applicable).

Select to display information for the previous three payers (if applicable).

<table>
<thead>
<tr>
<th>Payer 1-9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Type</td>
<td>NCPDP other payer coverage type</td>
</tr>
<tr>
<td></td>
<td>= Not Specified</td>
</tr>
</tbody>
</table>
Primary (#1) = First  
Secondary (#2) = Second  
Tertiary (#3) = Third  
Quaternary (4#4= Fourth  
Quinary (#5)= Fifth  
Senary (#6)= Sixth  
Septenary (#7)= Seventh  
Octonary (#8)= Eighth  
Nonary (#9)= Ninth  
Coupon  
Composite

**ID Qualifier**

NCPDP insurance ID qualifier  
= Not Specified  
National Payer ID  
HIN  
BIN  
NAIC  
Coupon  
Other

**ID**

NCPDP other payer ID

**Date**

Date other coverage was paid

### Other Payer Amounts Paid

<table>
<thead>
<tr>
<th>HC and DV Amount Paid/Qualifier</th>
<th>Amount Paid</th>
<th>Qualifier</th>
</tr>
</thead>
</table>
| Amount Paid - amount of any payment known by the pharmacy from other sources  
This field is filled only after a payer has approved the claim. It is used for Other Payer Amount Paid Billing and Medicaid Full Disclosure Billing, not for Copay Billing.  
Qualifier - code qualifying the Other Payer Amount Paid (HC)  
Blank = Not Specified  
01 Delivery Cost  
02 Shipping Cost  
03 Postage Cost  
04 Administrative Cost  
05 Incentive Cost  
06 Cognitive Service Cost |
<table>
<thead>
<tr>
<th></th>
<th>Drug Benefit Cost</th>
<th>Compound Preparation Cost</th>
<th>Sales Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>07</td>
<td>(for details on how EPS calculates this, see <a href="#">About COB Billing</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Compound Preparation Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Sales Tax</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select to open the **Qualifier** drop-down list, where you can select the option for the amount.

## Patient Responsibility Amounts

<table>
<thead>
<tr>
<th>NQ and NP Amount Paid/Qualifier</th>
<th>Amount Paid</th>
<th>Qualifier</th>
</tr>
</thead>
</table>

**Amount Paid** - 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) 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 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 |
| 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

Select to open the **Qualifier** drop-down list, where you can select the option for the amount.

---

### Benefit Stage Amounts

**MW and MV Amount Paid/Qualifier**

First field - amount of claim allocated to the Medicare stage identified by the **Benefit Stage Qualifier** (MV)

Second field - code qualifying **Benefit Stage Amount** (MW)

**Blank** = Not specified

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 - 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.

Select to open the **Qualifier** drop-down list, where you can select the option for the amount.

---

**This Fill - Exception**

Indicates the type of note displayed below, with label in green if that type of note is entered in the system

Select the type of note you want to view or add.

**[note text]**

Text of note

Select to display all notes.
Select to display the Notes History window.

Select to complete the CoB review task.

See Also

Add Payments to a Claim
Edit TP Information Window

The system displays the Edit TP Information window when you select the **Edit Tp Info** button on the Third Party Exception window.

**Third Party DAW**

Indicates to the third party why the brand or substitute was selected

- 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

**T/P 1**

Third party flag and plan-specific flag

For flag options, select **TP Flag Help**.

**T/P 2**

Third party flag and plan-specific flag

For flag options, select **TP Flag Help**.

**Fill Date to Submit**

Fill date the system uses when transmitting the prescription

Notes:
- To edit this field, you must have the Fill Date Edit role in your user group.
- If you display the Edit TP Information window for a secondary or tertiary third party, this field is blank; you cannot edit the field.

**Level of Service**

NCPDP level of service code that indicates the type of service the pharmacist performed

- 00 - Not Specified
- 01 - Patient Counsel
- 02 - Home Delivery
- 03 - Emergency
- 04 - 24 Hour Service
In-Home Service

**Incentive Fee**
Fee you submit to the third party because you performed a special procedure for this prescription or patient

**Other Coverage Code**
NCPDP coverage code to indicate the type of coverage from another payer
- **Blank or Ø - Not Specified**
- **1 - No Other Coverage**
- **2 - Payment Collected**
- **3 - This Claim Not Covered**
- **4 - Payment Not Collected**
- **5 - Mng Care Denial (5.1 Only)**
- **6 - Non-Part Prov (5.1 Only)**
- **7 - Cov Not In Effect (5.1 Only)**
- **8 - Claim is For Copay**

**Denial Clarification 1**
Indicates to the third party why they should pay the claim when they would normally deny it
- **1 - No Override**
- **2 - Other Override**
- **3 - Vacation Supply**
- **4 - Lost Prescription**
- **5 - Therapy Change**
- **6 - Starter/Trial Dose**
- **7 - Medical Necessary**
- **8 - Process Compound**
- **9 - Encounters**
- **10 - Meet Plan Limitation**
- **11 - Certification on File**
- **12 - DME Replacement Indicator**
- **13 - Payer Recognized Emergency**
- **14 - Leave of Absence**
- **15 - Replacement Medication**
- **16 - Emergency Box**
- **17 - Emergency Supply Reminder**
- **18 - Patient Admin/Readmit Indicator**
- **19 - Split Billing**
- **20 - Section 340B**
### Denial Clarification 2
Indicates to the secondary third party why they should pay the claim when they would normally deny it.
Options are listed in Denial Clarification 1.

### Denial Clarification 3
Indicates to the tertiary third party why they should pay the claim when they would normally deny it.
Options are listed in Denial Clarification 1.

### Place of Service
Code identifying the place where a drug or service is dispensed or administered.

### Delay Reason Code
Code specifying the reason that submission of the transactions has been delayed.
- **01** - Proof of eligibility unknown or unavailable
- **02** - Litigation
- **03** - Authorization delays
- **04** - Delay in certifying provider
- **05** - Delay in supplying billing forms
- **06** - Delay in delivery of custom-made appliances
- **07** - Third party processing delay
- **08** - Delay in eligibility determination
- **09** - 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

### 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.
- **01** - Community/Retail Pharmacy Services
- **02** - Compounding Pharmacy Services
- **03** - Home Infusion Therapy Provider Services
- **04** - Institutional Pharmacy Services
- **05** - Long Term Care Pharmacy Services
- **06** - Mail Order Pharmacy Services
- **07** - Managed Care Organization Pharmacy Services
- **08** - Specialty Care Pharmacy Services
### Authorization ID

**Type**

- Type of intermediary authorization: **Not Specified**, **Intermediary Auth, Other Override**

### Intermediary Auth. ID

- NCPDP value indicating that intermediary authorization occurred

### Procedure Modifier Code

- NCPDP procedure modifier code to indicate the type of procedure billed to the payer

**Notes:**

- Per the NCPDP data dictionary, these codes are available from the Health Care Financing Administration.
- For Nebraska Medicaid DME claims, **BO** (orally-administered nutritional products billed to Allwin) should be entered in this field.
- We provided support of this field specific to Allwin claim billing to Nebraska Medicaid. Allwin uses the data contained in the NCPDP format to build the HIPAA-compliant 837 claim format used to bill Nebraska Medicaid. Any other use of this field may not be HIPAA compliant. Consult your HIPAA compliancy officer prior to any other use.

### Rx Serial Form Number

- Field where you can enter the serial number printed on the prescription hard copy (required by some states)

**Note:** The **Rx Serial Number** dispensing rule determines whether the serial number is required. In addition, prescription edit message **212** determines whether the system displays a warning or hard halt edit message if the serial number is required and has not been entered. You maintain the dispensing rules on the PDX Host System. To define the settings for prescription edit messages, select **Administration > Edit Message**.

### Temporary Prescriber ID

- Temporary ID to use for the prescriber

### Prescriber ID Qualifier

- Temporary ID qualifier to associate with the selected service provider

**Options include:** **Not Specified**, **National Provider ID**, **Blue Cross ID**, **Blue Shield ID**, **Medicare ID**, **Medicaid ID**, **UPIN**, **NCPDP Provider ID**
<table>
<thead>
<tr>
<th>Prior Authorization Type</th>
<th>Indicates the type of prior authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Not Specified</td>
<td></td>
</tr>
<tr>
<td>1 - Prior Authorization #</td>
<td></td>
</tr>
<tr>
<td>2 - ML-Medical Certified</td>
<td></td>
</tr>
<tr>
<td>3 - EPSDT</td>
<td></td>
</tr>
<tr>
<td>4 - Exempt From Copay</td>
<td></td>
</tr>
<tr>
<td>5 - Exempt From Rx Limits</td>
<td></td>
</tr>
<tr>
<td>6 - Family Planning</td>
<td></td>
</tr>
<tr>
<td>7 - AFDC</td>
<td></td>
</tr>
<tr>
<td>8 - Payor Defined Exemption</td>
<td></td>
</tr>
<tr>
<td>9 - Emergency Preparedness</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Authorization Number</th>
<th>Prior authorization number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Repeat Option</th>
<th>Determines which fill of the prescription this authorization covers: THIS FILL ONLY, ALL FILLS OF RX</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Processed Date</th>
<th>Date the authorization was processed or entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA Effective Date</td>
<td>Date the authorization is effective</td>
</tr>
<tr>
<td>PA Expiration Date</td>
<td>Date the authorization expires</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>$ Amount Authorized</th>
<th>Maximum dollar amount this authorization allows</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th># Fills Authorized</th>
<th>Number of times you can fill this prescription under this authorization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Quantity Authorized</th>
<th>Total authorized quantity – any amount over is not authorized for coverage</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>$ Amount Used</th>
<th>Accumulated dollar amount used for this prior authorization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th># Fills Used</th>
<th>Number of fills for which this prior authorization has previously been used</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Quantity Used</th>
<th>Authorized quantity that has been dispensed</th>
</tr>
</thead>
</table>
### ICD-9 Diagnosis

<table>
<thead>
<tr>
<th>Code</th>
<th>ICD-9 code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Diagnosis associated with the ICD-9 code</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td></td>
</tr>
</tbody>
</table>

### NCPDP DUR Intervention

<table>
<thead>
<tr>
<th>Reason</th>
<th>Reason (conflict) codes that indicate problem(s) with the prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Service (intervention) codes that indicate what action(s) were taken (if any) because of the reason (conflict) code in the <em>Reason</em> column</td>
</tr>
<tr>
<td>Results</td>
<td>Result (outcome) codes that indicate the end result of the reason (conflicts) and services (interventions)</td>
</tr>
<tr>
<td>Effort Level</td>
<td>NCPDP level of effort codes that indicate the level of effort the pharmacist performed for each DUR listed in <em>Reason</em>, <em>Service</em>, and <em>Result</em></td>
</tr>
</tbody>
</table>

Select to add DUR codes for this prescription

**Use DUR Codes for all fills of this prescription.**

Determines whether the system stores the DUR codes for all fills of the prescription

Select to save the changes you made.

Select to cancel the changes you made and close the window.
**Manual Claim Override Window**

The system displays the Manual Claim Override window when you select **Claim Override** on the TP Exception window. On this window, you can manually update the payment information on a rejected claim for which you need to contact the third party to obtain oral authorization.

**Note:** To access this window, you must have the **Claim Override** role in your user group.

The following describes the fields on the Manual Claim Override window.

- **Rx #**
  - Prescription number

- **Tx #**
  - Transaction number

- **Patient**
  - Name of the patient for whom the prescription was filled

- **Drug**
  - Drug name and strength of dispensed drug

- **Plan Name**
  - Name of the insurance plan

- **Status**
  - Status of the transmittal: **Not Specified, Waiting, Sending, Received, Complete, Send Credit, Credit, Downtime**

- **Paid**
  - Paid status of the claim
    - **Paid** = third party received transmitted claim and paid in full
    - **Part** = third party received transmitted claim and partially paid for the claim
    - **Reject** = third party rejected the claim or reversal, or the transmission failed
    - **Credit** = third party accepted the claim reversal
    - **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

- **Reference #**
  - Reference number from the third party (used in transmitting reversals)

- **Amount Paid**
  - Amount paid by the third party

- **Copay**
  - Amount of the patient's copay

- **Save**
  - Select to save the changes you made to the claim.
Select to clear the information you entered.

Select to close the window.
Process Adjudication Result Window

The system displays the Process Adjudication Result window when you select **Next Task** and you are authorized to display Process Adjudication Result tasks. Your user role and workstation configuration determine whether you can process these tasks. The system creates a Process Adjudication Result task when you receive a response from a third party for a claim that was previously in downtime..

**Notes:**

- The **Process Adjudication Result** checkbox on the Workstation Configuration Workflow window determines if you can display Process Adjudication Result tasks at the workstation.
- The **Resolve Downtime Claim** user role determines whether a user can display Process Adjudication Result tasks.

The following describes the fields on the Process Adjudication Result window.

- **Patient Name**  
  Name of the patient for whom the prescription was filled
- **Date of Birth**  
  Patient's date of birth
- **Drug Name**  
  Drug name and strength of dispensed drug
- **Fill Date**  
  Date the prescription was filled
- **Rx Number**  
  Prescription number
- **Tx Number**  
  Transaction number
- **Status**  
  Status of the transmittal: **Not Specified, Waiting, Sending, Received, Complete, Send Credit, Credit, Downtime**
- **Paid**  
  Paid status of the claim
  
  - **No payment status received** = third party has not paid because the claim’s status is either **Waiting, Sending,** or **Send Credit**
  - **Paid** = third party received transmitted claim and paid in full
  - **Part Paid** = third party received transmitted claim and partially paid for the claim
  - **Rejected** = third party rejected the claim or reversal, or the
transmission failed

**Credit** = third party accepted the claim reversal

<table>
<thead>
<tr>
<th><strong>Plan Name</strong></th>
<th>Name of the insurance plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carrier ID</strong></td>
<td>Third party carrier ID</td>
</tr>
<tr>
<td><strong>Group ID</strong></td>
<td>Plan group identification number</td>
</tr>
<tr>
<td><strong>Plan ID</strong></td>
<td>Unique plan identification number</td>
</tr>
<tr>
<td><strong>Cardholder ID</strong></td>
<td>Cardholder identification number</td>
</tr>
</tbody>
</table>

**Coordination of Benefits**

Table that displays the patient's primary, secondary, and tertiary third parties as well as the status of the current claim for each third party

**Rx Workflow Information**

<table>
<thead>
<tr>
<th><strong>Sold Status</strong></th>
<th>Indicates if the prescription has been sold out of Will Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Next Task</strong></td>
<td>Next Workflow task to be completed for the prescription</td>
</tr>
</tbody>
</table>

**Copay Information** - This section displays the manually entered copay amount, the copay returned from the third party, and the difference.

- **Reprint Receipt** Select to print a new receipt for the prescription.
- **Add Patient Notes** Select to display the Patient Notes window, where you can add notes to the patient record.
- **Pricing Info** Select to display the Pricing Information window where you can view detailed pricing information for the claim.
- **Rejection Codes and Descriptions** Third party rejection codes and descriptions
- **Complete** Select to complete the Process Adjudication Result task.
Third Party Exception Window

The system displays the Third Party Exception window when you select Next Task and you are authorized to process Third Party Exception tasks. Your user role and workstation configuration determine whether you can process these tasks. The system creates a Third Party Exception task when the third party rejects the prescription or the prescription fails third party edits and adjudication.

Notes:

- The rejection codes the third party returns govern which user role gets the task, based on the settings in Administration > Third Party Exception Routing.
- If this prescription has expired, the system displays Rx has expired cannot fill. Select OK to close the message and return to the Third Party Exception window. The system cancels the prescription.

The following describes the fields on the Third Party Exception window.

- **Patient Name**: Name of the patient for whom the prescription was filled
- **Date of Birth**: Patient's date of birth
- **MRN**: Patient's medical record number
- **Drug Name**: Drug name and strength of dispensed drug
- **Fill Date**: Date the drug was entered to be filled
- **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
- **Status**: Status of the transmittal: Not Specified, Waiting, Sending, Received, Complete, Send Credit, Credit, Downtime
**Tx Number**  
Transaction number

**Paid**  
Paid status of the claim

- **No payment status received** = third party has not paid because the claim’s status is either **Waiting**, **Sending**, or **Send Credit**
- **Paid** = third party received transmitted claim and paid in full
- **Part Paid** = third party received transmitted claim and partially paid for the claim
- **Rejected** = third party rejected the claim or reversal, or the transmission failed
- **Credit** = third party accepted the claim reversal

**Reference #**  
Reference number from the third party (used in transmitting reversals)

**Type**  
Transmittal code located in the **Claim Format Code** field on the Insurance Plan—Transmit window for this plan

**Plan Name**  
Plan name for this patient's third party

- Select to display the prescription image or system-generated hardcopy.

**Carrier ID**  
Carrier ID for this patient's third party

**Plan ID**  
Plan ID for this patient's third party

**Group ID**  
Plan group for this patient's third party

**Cardholder ID**  
Cardholder ID for this patient's third party

**Coordination of Benefits**  
Up to nine third party plans and their status regarding this claim

- Select to display the cardholder and plan contact information on the Card Help window.

- Select to display the Claim Response Detail window for this third party exception. For more information, see [Claim Response Detail Window – Page 1](#).

- Select to display the Claim Transmit Detail window with the claim information for this third party exception. For more information, see [Claim Transmit Detail Window – Page 1](#).

**Rejection Codes and Descriptions**  
Third party rejection codes and descriptions

**Insurance Plan Messages**  
Rejection messages from the third party and transmission failure descriptions
**DUR Conflicts**  
Information regarding the Drug Utilization Review conflict

1. Conflict code and description that indicates the problem with the drug  
2. Drug information  
3. Last Filled – last date the prescription was filled  
4. Pharmacy – indicates what pharmacy filled the last fill: Not Specified, Your Pharmacy, Other in Same Chain, or Other Pharmacy  
5. Quantity – quantity of the dispensed drug  
6. Prescriber – indicates who prescribed the drug: Not Specified, Same Prescriber, Other Prescriber  
7. Severity – indicates severity of the conflict: Not Specified, Major, Moderate, Minor

**Notes for...**  
Field where you can enter and edit several types of notes associated with the prescription
Select the radio button to display the note you want to add, edit, or view. If the label is green, that type of note is stored in the system.

**This Fill** - Note the system displays only for the current fill of the prescription  
**All Fills** - Note the system displays for all fills of the prescription  
**Patient** - Note entered on the patient record that is set up to display at the Order Entry station  
**Prescriber** - Note entered on the prescriber record that is set up to display at the Order Entry station  
**Exception** - Exception note associated with the prescription  
**Mail Order** - Mail order related notes associated with the prescription that are helpful for processing the order The system prints the note on the mail order receipt.  
**Note to Patient** - Important information you want to tell a patient directly or via the Elixir receipt.

[**note text**]  
Text of note
Select to display all notes.

Select to display the Notes History window.
Select to display the Patient Third Party window.

Select to display the Cardholder window.

Select to display the Prescriber Third Party window.

Select to display the Drug TP Info window.

Select to display the Drug NDC History window, where you can view any previous NDC numbers that were assigned to the drug.

Select to display the Coordination of Benefits Review window, where you can view information transmitted to additional third parties for the claim. For more information, see Coordination of Benefits Review window.

Select to display the Edit TP Information window, where you can change certain information before re-transmitting a claim.

Select to display the Edit Billing Information window, where you can select Cash or another third party for billing. For field descriptions, see Edit Billing Information Window.

Select to display the Pricing Information window. For field descriptions, see Pricing Information Window.

Select to fill the transaction as cash.

Select to display the Manual Claim Override window, where you can manually update the status and payment information for the claim.

For more information, see Manually Update Claim.

Select to print a Third Party Reject Information sheet for that prescription.

For more information, see Third Party Reject Information Report.

Select to retransmit the claim to the third party with the changes you made.

Select to reverse a paid claim.

Select to complete the third party exception process.
**Third Party Exception - Reject Options Window**

To access the Third Party Exception - Reject Options window, select **Reject** from any Third Party Exception window.

**Note:** If you attempt to cancel the completion fill of a prescription while the partial fill is still in workflow, the system displays: **If you cancel the Completion Fill transaction, the corresponding Partial Fill will also be canceled. Continue?**

The following describes the fields on the Data Entry - Reject Options window.

<table>
<thead>
<tr>
<th><strong>Promised</strong></th>
<th>Date the prescription was originally promised for delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Refill Too Soon</strong></td>
<td>Indicates that you are rejecting the prescription because it is not yet time to refill it. The system displays the <strong>Refill On</strong> field for you to enter the date the prescription is eligible for refill.</td>
</tr>
</tbody>
</table>
| **Requires Review** | The system displays the following checkboxes for you to select describing the type of review required:  
  - **Low pay**  
  - **DUR**  
  - **Other** |
| **Need More Information** | Indicates that you need more information from the prescriber or patient. The system displays the following fields. |
| **Prescriber** | Indicates that you need more information from the prescriber. When you select this option, system displays the following fields:  
  - **Message Left** - Indicates that you left a message for the prescriber  
  - **Next Call Date and Time** - Date and time you want to schedule the next Call task  
  - **For Entire Clinic** - Indicates the schedule change is for the clinic  
  - **For Individual Prescriber** - Indicates the schedule change is |
for the prescriber

- **Schedule** - Days and times the prescriber works at the clinic
  You can change the schedule by double-clicking in a cell and entering a new time.

**Patient**

Indicates that you need more information from the patient
When you select this option, the system displays the following fields. You can either send a patient message (for Mail to Patient orders only) or set a Call Patient task for a specific date.

- **Send Outbound Patient Message** - Select to send a message to the patient. The system displays the **Send Outbound Patient Message** option only if the order type is Mail to Patient.

- **Outbound Message Reason** - Select a reason you are sending a message. The system displays this option only if the order type is Mail to Patient.
  - *Billing Issues*
  - *Pending Payment*
  - *Copay Review*
  - *Non-Mailable*
  - *Refill Too Soon*
  - *Rx Price greater than threshold*
  - *Consultation First Fill*
  - *Order Delay*
  - *Refill Authorization Denied*
  - *Rx Discontinued*
  - *Non Member*
  - *We Have A Question*
  - *Refill Pending Authorization*
  - *New KPHC Mail Order Rx*

- **Message Left** - Select if you left a message for the prescriber.

- **Next Call Date and Time** - Date and time you want to schedule the next Call task

**Insurance Plan**

Indicates that you need more information from the insurance plan
When you select this option, the system displays the following fields.

- **Message Left** - Select if you left a message for the prescriber.
- **Next Call Date and Time** - Date and time you want to schedule the next Call task

**Put Claim in Downtime**
Indicates that the transmission failed and you want to continue filling the prescription
When you select this option, the system displays the following fields.
- **Continue Fill. Enter Copay**
- **Copay**

**Cancel This Prescription**
Indicates that you are cancelling this prescription
The system displays the following fields:

**Send Outbound Patient Message**
Select to send a message to the patient. When you select this option, the system enables the **Outbound Message Reason** drop-down list. The system displays this option if the order type is Mail to Patient.

**Outbound Message Reason**
Reason you are sending a message
The system enters the corresponding text in the **Description** field. The system displays this option only if the order type is Mail to Patient.
- **Billing Issues**
- **Pending Payment**
- **Copay Review**
- **Non-Mailable**
- **Refill Too Soon** - If you select this message reason, the system selects **Refill Too Soon** as the cancellation reason. You cannot select another cancellation reason.
- **Rx Price greater than threshold**
- **Consultation First Fill**
- **Order Delay**
- **Refill Authorization Denied**
- **Rx Discontinued**
- **Non Member**
- **We Have A Question**
- **Refill Pending Authorization**

**Cancel and leave the Rx active**
Indicates that you are cancelling the prescription and leaving it active in the system
When you select this option, the system enables the **Cancel**
Reason drop-down list.

**Cancel Reason**
Reason you are canceling this prescription
The system enters the corresponding text in the **Description** field.
- Patient Cannot Afford Medication
- Patient Does not want Medication
- Patient has sufficient Qty at Home
- Patient used previously, did not like/work
- Patient refused after hearing side effects
- Refill Too Soon
- Other Reason

**Cancel and deactivate the Rx**
Indicates that you are cancelling and deactivating the prescription
When you select this option, the system enables the **Deactivate Reason** drop-down list.

**Deactivate Reason**
Reason you are deactivating this prescription
- Allergic
- Duplicate Therapy
- No Longer Used
- Not Tolerating Side Effects
- Order Entry Error
- Other Reason
- Patient Requested
- Therapy Change
- Replaced by Pharmacy
- Transferred to Outside Pharmacy
- Transferred to Internal Pharmacy Outside Region
- Transferred to Internal Pharmacy Inside Region

**Return to Data Entry for Correction**
Indicates that you are returning the prescription to Data Entry to correct data entry errors
The system displays checkboxes for you to select describing the type of Data Entry error.

**Display at the Local Store Only**
Indicates that this prescription should be processed at the local store (used when you are processing prescriptions using Alternate Site)
When you select **Display at the Local Store Only**, the system
removes all fields except the **Description** field, where you must enter a reason the task should be processed at the local store (for example, you cannot read the prescription).

**Description**
Reason you cannot complete the task

Select to return to the Third Party Exception window without saving your changes.
Select to complete the rejection/message.

**See Also**
- Reject - Add Call Task
- Reject - Cancel Prescription
- Reject - Put Claim in Downtime
- Reject - Refill Too Soon
- Reject - Return to Data Entry
- Reject - Send to TP Exception Queue
TP Exception Queue Window

On the TP Exception Queue window, the system displays all third party exceptions waiting to be processed at your store. These are claims the third party has rejected. You need to process the records on the Third Party Exception window and complete a successful adjudication or fill them as cash to complete the filling process.

To access the TP Exception Queue window, select **Tools > Task Queue > TP Exception Queue**, or press **Ctrl + T** from any window in the system. The following describes the fields on the TP Exception Queue window.

**Search Criteria** - Use the top section of the window to enter the criteria you want to use to view prescriptions in the TP Exception queue.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>Last name of the patient</td>
</tr>
<tr>
<td>First Name</td>
<td>First name of the patient</td>
</tr>
<tr>
<td>Rx Number</td>
<td>Prescription number</td>
</tr>
<tr>
<td>Tx Number</td>
<td>Transaction number</td>
</tr>
<tr>
<td>Carrier ID</td>
<td>Third party carrier ID</td>
</tr>
<tr>
<td>Paid</td>
<td>Determines which claims the system displays based on the paid status of the claim</td>
</tr>
<tr>
<td></td>
<td><strong>Paid</strong> = third party received the transmitted claim and paid in full</td>
</tr>
<tr>
<td></td>
<td><strong>Part Paid</strong> = third party received the transmitted claim and partially paid for the claim</td>
</tr>
<tr>
<td></td>
<td><strong>Rejected</strong> = third party rejected the claim or reversal, or the transmission failed</td>
</tr>
<tr>
<td></td>
<td><strong>Credit</strong> = third party accepted the claim reversal</td>
</tr>
<tr>
<td></td>
<td><strong>Low Pay</strong> = 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</td>
</tr>
<tr>
<td>Status</td>
<td>Determines which claims the system displays based on the claim status</td>
</tr>
<tr>
<td></td>
<td><strong>Waiting</strong> = system has not started to transmit the claim</td>
</tr>
<tr>
<td></td>
<td><strong>Sending</strong> = system is in the process of transmitting the claim</td>
</tr>
</tbody>
</table>
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
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 that 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

Select to filter the queue based on the criteria you entered. The system displays only the prescriptions that match your criteria.

**Keywords List** - Displays the prescription in the queue based on the criteria you entered

| KP Rx | Standard prescription number for the order. This number is unique not just as the pharmacy, but across Kaiser. This number remains the same until the drug, quantity, SIG, or prescription 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 |
| Tx Number | Transaction number |
| Carrier ID | Third party carrier ID |
| Sequence | Third party billing sequence |
| Patient Name | Patient name |
| Drug Name | Drug name |
| Filled Date | Date the prescription was filled |
| Paid | Paid status of the claim |
**Paid** = third party received the transmitted claim and paid in full

**Part Paid** = third party received the transmitted claim and partially paid for the claim

**Rejected** = third party rejected the claim or reversal, or the transmission failed

**Credit** = third party accepted the claim reversal

**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

**Status**

Status of the transmittal

**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 that 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

**Downtime**

Indicates if the claim is in downtime to be transmitted at a later date

Select to display the highlighted prescription on the Third Party Exception window.

**Adjudication Results**

**Rx Number**

Prescription number

**Tx Number**

Transaction number
<table>
<thead>
<tr>
<th><strong>Retransmit On</strong></th>
<th>Date the transaction is scheduled to be retransmitted to the third party</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reject Codes and Description</strong></td>
<td>Third party rejection codes and descriptions</td>
</tr>
<tr>
<td><strong>Insurance Plan Message</strong></td>
<td>Rejection messages from the third party and transmission failure descriptions</td>
</tr>
<tr>
<td>COB Segment</td>
<td>Primary Loop</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Delivery)</td>
<td>$10.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Compound)</td>
<td>$6.00 +$6.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Comp)</td>
<td>$4.00 +$4.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Sales Tax)</td>
<td>$4.50 +$4.50</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Drug Benefit)</td>
<td>$73.00 -$73.00</td>
</tr>
</tbody>
</table>

$97.50 Other Payor Amt Recognized (cell D40 below)

<table>
<thead>
<tr>
<th>Response Pricing</th>
<th>Primary Response</th>
<th>Secondary Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>506-F6 Ingredient Cost Paid</td>
<td>$90.00</td>
<td>$89.00</td>
</tr>
<tr>
<td>507-F7 Dispensing Fee Paid</td>
<td>$3.00</td>
<td>$3.50</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Delivery)</td>
<td>$10.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Compound)</td>
<td>$6.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>521-FL Incentive Amount Paid</td>
<td>$4.00</td>
<td>$4.45</td>
</tr>
<tr>
<td>565-J4 Percentage Sales Tax Amount Paid</td>
<td>$4.50</td>
<td>$4.45</td>
</tr>
<tr>
<td>564-J2 Percentage Sales Tax Basis Paid</td>
<td>0.05</td>
<td>0.05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request Pricing Segment Sent to Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>409-D9 Ingredient Cost Submitted</td>
</tr>
<tr>
<td>412-D9 Dispensing Fee Submitted</td>
</tr>
<tr>
<td>409-J9 Other Amt Claimed Submitted (Delivery)</td>
</tr>
<tr>
<td>409-J9 Other Amt Claimed Submitted (Compound)</td>
</tr>
<tr>
<td>438-E3 Incentive Amount Submitted</td>
</tr>
<tr>
<td>Percent Sales Tax Amount</td>
</tr>
<tr>
<td>Percentage Sales Tax Basis</td>
</tr>
<tr>
<td>Percentage Sales Tax Rate</td>
</tr>
<tr>
<td>439-DU Gross Amount Due</td>
</tr>
<tr>
<td>439-DQ Usual and Customary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COB Segment</th>
<th>Primary Occurrence</th>
<th>Secondary Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>565-J4 Other Amount Paid (Delivery)</td>
<td>$10.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Compound)</td>
<td>$6.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>521-FL Incentive Amount Paid</td>
<td>$4.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Sales Tax)</td>
<td>$4.50</td>
<td>$0.00</td>
</tr>
<tr>
<td>565-J4 Other Amount Paid (Drug Benefit)</td>
<td>$73.00</td>
<td>$11.45</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>COB Segment</td>
<td>Primary Occurrence</td>
<td>Secondary Occurrence</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>55</td>
<td>505-J4 Other Amount Paid (Delivery)</td>
<td>$10.00</td>
<td>$0.00</td>
<td>F Primary Delivery &gt; Secondary, show 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>$10.00 - $0.00 = $10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>505-J4 Other Amount Paid (Compound)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>F Primary Compound &gt; Secondary, show 0</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>58</td>
<td>$0.00 - $0.00 = $0.00</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>57</td>
<td>521-FL Incentive Amount Paid</td>
<td>$4.00</td>
<td>$1.00</td>
<td>F Primary Incentive &gt; Secondary, show 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>$4.00 - $1.00 = $3.00</td>
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<td></td>
</tr>
<tr>
<td>58</td>
<td>505-J4 Other Amount Paid (Sales Tax)</td>
<td>$4.50</td>
<td>$0.00</td>
<td>F Primary Tax &gt; Secondary, show 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>$4.50 - $0.00 = $4.50</td>
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<td></td>
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</tr>
<tr>
<td>59</td>
<td>505-J4 Other Amount Paid (Drug Benefit)</td>
<td>$73.00</td>
<td>$11.45</td>
<td></td>
<td></td>
<td></td>
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<td>$73.00 - $11.45 = $84.45</td>
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</tr>
<tr>
<td>61</td>
<td>Other Payer Amnt Recognized (call E71 below)</td>
<td></td>
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<td></td>
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<td>62</td>
<td>Responses Pricing</td>
<td>Primary Response</td>
<td>Secondary Response</td>
<td>Tertiary Response</td>
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<tr>
<td>63</td>
<td>506-F6 Ingredient Cost Paid</td>
<td>$90.00</td>
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<td>$90.00</td>
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<tr>
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<td>507-F7 Dispensing Fee Paid</td>
<td>$3.00</td>
<td>$3.50</td>
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<td></td>
<td></td>
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<td></td>
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<td>67</td>
<td>$10.00 - $0.00 = $10.00</td>
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<tr>
<td>68</td>
<td>505-J4 Other Amount Paid (Compound)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td></td>
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<td>69</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>70</td>
<td>521-FL Incentive Amount Paid</td>
<td>$4.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
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<td>71</td>
<td>$4.00 - $0.00 = $4.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>505-J4 Other Amount Paid (Sales Tax)</td>
<td>$4.50</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>73</td>
<td>$4.50 - $0.00 = $4.50</td>
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<tr>
<td>74</td>
<td>505-J4 Other Amount Paid (Drug Benefit)</td>
<td>$73.00</td>
<td>$11.45</td>
<td>$6.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>75</td>
<td>$73.00 - $11.45 = $84.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>509-F9 Total Amount Paid</td>
<td>$97.50</td>
<td>$12.45</td>
<td>$6.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>$97.50 - $12.45 = $84.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>505-F6 Ingredient Cost Paid</td>
<td>$90.00</td>
<td>$90.00</td>
<td>$90.00</td>
<td></td>
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</tr>
<tr>
<td>80</td>
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**Other Payer Amt Recognized**

(cell C103 below)

$104.95 = Quaternary Net Amt Paid - $8.10

**Pharmacy Net Sell Price**

$124.10

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