RealRx Payer Sheet

REALR_x

GENERAL INFORMATION

Payer Name: RealRx/Cooperative Benefits Group	Date: 11**/12/2025**		

Plan Name/Group Name: ALL	BINs:		
	BIN	**PCN**	**Phone Number**
	028181	REALRX	855.212.2110

Processor: Cervey, LLC	
Effective as of: 12/01/2025	NCPDP Telecommunication Standard Version/Release #: vD.0
NCPDP Data Dictionary Version Date: January 2017	NCPDP External Code List Version Date: January 2017

Provider Relations Help Desk Info:

BIN	**PCN**	**Phone Number**
028181	REALRX	855.212.2110

TRANSACTIONS SUPPORTED

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal

Test Data	**Healthy U**
BIN	028181
PROCESSOR CONTROL NUMBER	REALRX
GROUP	Optional
CARDHOLDER ID	999991240
PERSON CODE	001
PATIENT FIRST and LAST NAME	Janice Litman
RELATIONSHIP CODE	1 - Cardholder
DATE OF BIRTH	03/19/1955

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	
NOT CURRENTLY IN USE		The Field is not currently in use for the Segment in the designated transaction.	

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CLAIM BILLING TRANSACTION

The following lists segments and fields in a Claim Billing (B1) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Transaction Header Segment Questions	Check	Claim Billing If Situational, *Payer Situation*		
This Segment is always sent	X			
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X			
	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	**028181**	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	*Refer to Member Card*	M	
1Ø9-A9	TRANSACTION COUNT		M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	National Provider ID (NPI) is Required
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent	X			
	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
312-CC	CARDHOLDER FIRST NAME			
313-CD	CARDHOLDER LAST NAME			
314-CE	HOME PLAN			
524-FO	PLAN ID			
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE			
3Ø1-C1	GROUP ID		R	
3Ø3-C3	PERSON CODE		RW	Required when necessary to identify dependents with same birthdate.
3Ø6-C6	PATIENT RELATIONSHIP CODE		R	
359-2A	MEDIGAP ID			
36Ø-2B	MEDICAID INDICATOR			
361-2D	PROVIDER ACCEPT ASSIGNMENT INDICATOR			
997-G2	CMS PART D DEFINED QUALIFIED FACILITY			
115-N5	MEDICAID ID NUMBER			

Patient Segment Questions	Check	Claim Billing If Situational, *Payer Situation*		
This Segment is always sent	X			
This Segment is situational				
	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

331-CX	PATIENT ID QUALIFIER			
332-CY	PATIENT ID			
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS			
323-CN	PATIENT CITY ADDRESS			
324-CO	PATIENT STATE / PROVINCE ADDRESS			
325-CP	PATIENT ZIP/POSTAL ZONE			
326-CQ	PATIENT PHONE NUMBER			
3Ø7-C7	PLACE OF SERVICE		RW	Required when necessary for plan benefit administration.
333-CZ	EMPLOYER ID			
335-2C	PREGNANCY INDICATOR			
35Ø-HN	PATIENT E-MAIL ADDRESS			
384-4X	PATIENT RESIDENCE		RW	Required when necessary for plan benefit administration.

Claim Segment Questions		Check	Claim Billing If Situational, *Payer Situation*		
This Segment is always sent		X			
This payer supports partial fills					
This payer does not support partial fills					
	Claim Segment **Segment Identification (111-AM) = "Ø7"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing		M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER			M	
436-E1	PRODUCT/SERVICE ID QUALIFIER			M	
4Ø7-D7	PRODUCT/SERVICE ID			M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER			RW	Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = '"C" (completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE			RW	Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = '"C" (completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription
458-SE	PROCEDURE MODIFIER CODE COUNT				

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
459-ER	PROCEDURE MODIFIER CODE			
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	0, 1 or 2	R	0 – Not Specified 1 – Not a Compound 2 – Compound
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	CCYYMMDD
415-DF	NUMBER OF REFILLS AUTHORIZED		R	
419-DJ	PRESCRIPTION ORIGIN CODE		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3	RW	Required when Submission Clarification Code (420-DK) is used
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	Required for specific overrides or when requested by processor
460-ET	QUANTITY PRESCRIBED		RW	Required with schedule II controlled medication
3Ø8-C8	OTHER COVERAGE CODE		RW	Required for coordination of benefits
429-DT	SPECIAL PACKAGING INDICATOR			
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER			
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE			
446-EB	ORIGINALLY PRESCRIBED QUANTITY			
454-EK	SCHEDULED PRESCRIPTION ID NUMBER			
6ØØ-28	UNIT OF MEASURE			
418-DI	LEVEL OF SERVICE			
461-EU	PRIOR AUTHORIZATION TYPE CODE			
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED			
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID			
464-EX	INTERMEDIARY AUTHORIZATION ID			
343-HD	DISPENSING STATUS		RW	Claim Billing/Encounter: Required for the partial fill or the completion fill of a Prescription.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	Claim Billing/Encounter: Required for the partial fill or the completion fill of a Prescription.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	Claim Billing/Encounter: Required for the partial fill or the completion fill of a Prescription.
357-NV	DELAY REASON CODE			
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)			
995-E2	ROUTE OF ADMINISTRATION		RW	Required if specified in trading partner agreement.
996-G1	COMPOUND TYPE			
147-U7	PHARMACY SERVICE TYPE			

Pricing Segment Questions		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*	
This Segment is always sent		X		
	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	
433-DX	PATIENT PAID AMOUNT SUBMITTED		RW	Required if this field could result in different coverage, pricing or patient financial responsibility.
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Required when requested by processor
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3	RW	Required if Other Amount Claimed Submitted Qualifier (479-H8) is used.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	Required if Other Amount Claimed Submitted Qualifier (480-H9) is used.
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	Required if its value affects the Gross Amount Due (430-DU) calculation.
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	Required if its value affects the Gross Amount Due (430-DU) calculation.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	Required if its value affects the Gross Amount Due (430-DU) calculation.
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		RW	Required if needed for receiver claim/encounter adjudication.

Pharmacy Provider Segment Questions		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent					
This Segment is situational					
	Pharmacy Provider Segment **Segment Identification (111-AM) = "Ø2"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*	
465-EY	PROVIDER ID QUALIFIER				
444-E9	PROVIDER ID				

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Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent	X			
This Segment is situational				
	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER		R	
411-DB	PRESCRIBER ID		R	
427-DR	PRESCRIBER LAST NAME			
498-PM	PRESCRIBER PHONE NUMBER			
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER			
421-DL	PRIMARY CARE PROVIDER ID			
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME			
364-2J	PRESCRIBER FIRST NAME			
365-2K	PRESCRIBER STREET ADDRESS			
366-2M	PRESCRIBER CITY ADDRESS			
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS			
368-2P	PRESCRIBER ZIP/POSTAL ZONE			

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational	X	Required only for secondary, tertiary, etc. claims.		
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	Scenario 1 is supported		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only				
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)				
	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** **Scenario 1 - Other Payer Amount Paid Repetitions Only**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9	M	.
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	03=BIN	R	
34Ø-7C	OTHER PAYER ID	6 Digit BIN	R	
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 3	R	
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		R	
431-DV	OTHER PAYER AMOUNT PAID		R	
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5	R	
472-6E	OTHER PAYER REJECT CODE		R	

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	Workers' Compensation Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
	This Segment is always sent				
	This Segment is situational	X			
	Workers' Compensation Segment Segment Identification (111-AM) = "Ø6"				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
434-DY	DATE OF INJURY			M	
315-CF	EMPLOYER NAME			RW	Require all if this segment is submitted
316-CG	EMPLOYER STREET ADDRESS			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
317-CH	EMPLOYER CITY ADDRESS			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
318-CI	EMPLOYER STATE/PROVINCE ADDRESS			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
319-CJ	EMPLOYER ZIP/POSTAL ZONE			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
32Ø-CK	EMPLOYER PHONE NUMBER			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
321-CL	EMPLOYER CONTACT NAME			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
327-CR	CARRIER ID			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
435-DZ	CLAIM/REFERENCE ID			RW	Required if needed to process a claim/encounter for a work-related injury or condition.
117-TR	BILLING ENTITY TYPE INDICATOR			R	
118-TS	PAY TO QUALIFIER			RW	Required if Pay To ID (119-TT) is used.
119-TT	PAY TO ID			RW	Required if transaction is submitted by a provider or agent but paid to another party.
12Ø-TU	PAY TO NAME			RW	Required if transaction is submitted by a provider or agent but paid to another party.
121-TV	PAY TO STREET ADDRESS			RW	Required if transaction is submitted by a provider or agent but paid to another party.
122-TW	PAY TO CITY ADDRESS			RW	Required if transaction is submitted by a provider or agent but paid to another party.
123-TX	PAY TO STATE/PROVINCE ADDRESS			RW	Required if transaction is submitted by a provider or agent but paid to another party.
124-TY	PAY TO ZIP/POSTAL ZONE			RW	Required if transaction is submitted by a provider or agent but paid to another party.
125-TZ	GENERIC EQUIVALENT PRODUCT ID QUALIFIER			RW	Required if Generic Equivalent Product ID (126-UA) is used.
126-UA	GENERIC EQUIVALENT PRODUCT ID			RW	Required if necessary for state/federal/regulatory agency programs.

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REALRx

DUR/PPS Segment Questions		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent					
This Segment is situational		X			
	DUR/PPS Segment **Segment Identification (111-AM) = "Ø8"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences		RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE			RW	Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.
44Ø-E5	PROFESSIONAL SERVICE CODE			RW	Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.
441-E6	RESULT OF SERVICE CODE			RW	Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.
474-8E	DUR/PPS LEVEL OF EFFORT			RW	
475-J9	DUR CO-AGENT ID QUALIFIER			RW	
476-H6	DUR CO-AGENT ID			RW	

Coupon Segment Questions		Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*		
This Segment is always sent					
This Segment is situational		X			
	Coupon Segment **Segment Identification (111-AM) = "Ø9"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
485-KE	COUPON TYPE			M	
486-ME	COUPON NUMBER			M	
487-NE	COUPON VALUE AMOUNT				

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

363-2H	COMPOUND INGREDIENT MODIFIER CODE			

Clinical Segment Questions		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*		
This Segment is always sent					
This Segment is situational		X			
	Clinical Segment **Segment Identification (111-AM) = "13"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5		M	
492-WE	DIAGNOSIS CODE QUALIFIER			M	
424-DO	DIAGNOSIS CODE			M	
493-XE	CLINICAL INFORMATION COUNTER	Maximum 5 occurrences supported		RW	Grouped with Measurement fields (Measurement Date (494-ZE), Measurement Time (495-H1), Measurement Dimension (496-H2), Measurement Unit (497-H3), Measurement Value (499-H4).
494-ZE	MEASUREMENT DATE			RW	Required if necessary when this field could result in different coverage and/or drug utilization review outcome.
495-H1	MEASUREMENT TIME			RW	Required if Time is known or has impact on measurement.
496-H2	MEASUREMENT DIMENSION			RW	Required if Measurement Unit (497-H3) and Measurement Value (499-H4) are used.
497-H3	MEASUREMENT UNIT			RW	Required if Measurement Dimension (496-H2) and Measurement Value (499-H4) are used.
499-H4	MEASUREMENT VALUE			RW	Required if Measurement Dimension (496-H2) and Measurement Unit (497-H3) are used.

Additional Documentation Segment Questions		**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*		
This Segment is always sent					
This Segment is situational		X			
	Additional Documentation Segment **Segment Identification (111-AM) = "14"**				**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*		*Payer Usage*	*Payer Situation*
369-2Q	ADDITIONAL DOCUMENTATION TYPE ID			M	Mandatory if Segment is submitted.
374-2V	REQUEST PERIOD BEGIN DATE				
375-2W	REQUEST PERIOD RECERT/REVISED DATE				
373-2U	REQUEST STATUS				
371-2S	LENGTH OF NEED QUALIFIER				
37Ø-2R	LENGTH OF NEED				
372-2T	PRESCRIBER/SUPPLIER DATE SIGNED				
376-2X	SUPPORTING DOCUMENTATION				
377-2Z	QUESTION NUMBER/LETTER COUNT	Maximum count of 5Ø			
378-4B	QUESTION NUMBER/LETTER				
379-4D	QUESTION PERCENT RESPONSE				
38Ø-4G	QUESTION DATE RESPONSE				
381-4H	QUESTION DOLLAR AMOUNT RESPONSE				
382-4J	QUESTION NUMERIC RESPONSE				

383-4K	QUESTION RESPONSE	ALPHANUMERIC			

** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template**

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

CLAIM REVERSAL TRANSACTION

Transaction Header Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*		
This Segment is always sent	X			
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued				
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued				
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used				
	Transaction Header Segment			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	**028181**	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	*Refer to Member Card*	M	
1Ø9-A9	TRANSACTION COUNT		M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	

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11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*		
This Segment is always sent	X			
This Segment is situational				
	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID		RW	Required when necessary to identify the member and the transaction to be reversed.
359-2A	MEDIGAP ID			

Claim Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*		
This Segment is always sent	X			
	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
4Ø3-D3	FILL NUMBER		RW	Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day.
3Ø8-C8	OTHER COVERAGE CODE		RW	Required if needed to match claim being reversed.
147-U7	PHARMACY SERVICE TYPE			

Pricing Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational				
	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
438-E3	INCENTIVE AMOUNT SUBMITTED			
43Ø-DU	GROSS AMOUNT DUE			

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational	X	Segment Required when coordination of benefits is intended for saction		
	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9	M	.

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338-5C	OTHER PAYER COVERAGE TYPE		M	

DUR/PPS Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*		
This Segment is always sent				
This Segment is situational	X			
DUR/PPS Segment **Segment Identification (111-AM) = "Ø8"**				**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences		
439-E4	REASON FOR SERVICE CODE			
44Ø-E5	PROFESSIONAL SERVICE CODE			
441-E6	RESULT OF SERVICE CODE			
474-8E	DUR/PPS LEVEL OF EFFORT			

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

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