

**Pharmacy Data Management, Inc.  
NCPDP Version 5.1  
PAYER SHEET**

**\*\*GENERAL INFORMATION\*\***

<b>Payer Name:</b> Pharmacy Data Management, Inc.	<b>Date:</b> January 2008
<b>Plan Name/Group Name:</b>	
<b>Processor:</b> Pharmacy Data Management, Inc.	<b>Switch:</b> WebMD, NDCHealth, Direct Dial
<b>Effective as of:</b> January 1, 2006	<b>Version/Release #:</b> 5.1
<b>Contact/Information Source:</b> 800-800-PDMI x. 5410 (Technical Programming Line for Set-ups)	
<b>Certification Testing Window:</b> Not required	
<b>Provider Relations Help Desk Info:</b> 800-767-4226	
<b>Other versions supported:</b> 3.2 / 3A / 3C	

**\*\*Version 5.1 Transactions Supported : All other transactions to be determined in future**

Transaction Code	Transaction Name	Transaction Support Requirements	Implementation Date
B1	Billing	Required	07/01/2003
B2	Reversal	Required	07/01/2003
B3	Re-bill	Required	07/01/2003

**\*\* Version 5.1 Transaction Segments Mandatory/Situational/Not Sent:**

Transaction Code	B1	B2	B3	Segment Support Requirements
<b>Segment</b>				
Header	M	M	M	Required 07/01/2003
Patient	M	S	M	Required 07/01/2003
Insurance	M	S	M	Required 07/01/2003
Claim	M	M	M	Required 07/01/2003
Pharmacy Provider	S	N	S	No planned requirements at this time; may be required in future
Prescriber	M	N	M	Required 07/01/2003
COB/Other payments	S	N	S	Required for COB claims processing 10/01/2004
Workers' Comp	S	N	S	Not Required
DUR/PPS	S	S	S	Required for Vaccine Admin Medicare Part D 1/1/2008
Pricing	M	S	M	Required 07/01/2003
Coupon	S	N	S	No planned requirements at this time; may be required at a future date.
Compound	S	N	S	Required Future date
PA	S	N	S	Required Future date
Clinical	S	N	S	Not Required

**NCPDP Designations: M=Mandatory (required at all times; S=Situational (required in designated conditions); N=Not Sent (not necessary).**

**NOTE: Some segments indicated as "Situation" by NCPDP, may be "Required" to support specific transactions for this program.**

**\*\*Version 5.1 Important program Highlights for Medicare Part D**

<i>COB claims processing are currently being processed for Medicaid clients and specialty programs. Effective 01/01/2006 – Medicare Part D supplemental Billing will begin.</i>
<i>Only one Medicare claim may be submitted per transaction to eliminate confusion in the calculation of TrOOP. (Multiple claims will not be supported)</i>
<i>Compounds will be processed on-line in the current manner by using the most expensive NDC .</i>
<i>Partial Fills will not be supported .</i>
<i>Provider Software should support any/all data elements on the required segments.</i>

**BILLING TRANSACTION:**

**\*\*SEGMENTS\*\***

M = Mandatory  
R = Required  
RW = Required When

Transaction HEADER SEGMENT		MANDATORY IN ALL CASES		
Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	610020, 006012,013535,012528	M	
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B1, B2, B3	M	
1Ø4-A4	Processor Control Number	<b>For Secondary Med Part D use ONLY:</b> MEDDPDM <b>For Primary MAPD plan use:</b> MEDD0435 (Printed on Cards)	M	
1Ø9-A9	Transaction Count	B1 = 1 – 4 B2 = 1 – 4 B3 = 1 – 4	M	<b>Only 1 transaction is permitted for Medicare Part D and COB billing</b>
2Ø2-B2	Service Provider ID Qualifier	01 – NPI 07 – NCPDP Number	M	
2Ø1-B1	Service Provider ID		M	<b>Effective May 23, 2007 – PDMI will only accept the NPI as the valid Service Provider ID</b>
4Ø1-D1	Date of Service	Format = CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID	Blank	M	

- If submitting **supplemental** prescription claims as a secondary payer for Medicare Part D, the PCN must be designated as:

**MEDDPDM**

- PDM still requires an Rx Group number be submitted on a claim in order to process it properly. This Rx Group number can always be found on the ID card.

<b>Transaction INSURANCE SEGMENT</b>		<b>MANDATORY for B1 and B3</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	
3Ø9-C9	Eligibility Clarification Code		S	
3Ø1-C1	Group Id		R	Varies by Plan & Printed on Id Card
3Ø3-C3	Person Code		R	
3Ø6-C6	Patient Relationship Code	1, 2, 3	R	1 = Cardholder 2 = Spouse 3 = Dependent

<b>Transaction PATIENT SEGMENT</b>		<b>MANDATORY for B1 and B3</b>		
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø1	M	Patient Segment
3Ø4-C4	Date of Birth	Format = CCYYMMDD	R	
3Ø5-C5	Patient Gender Code	1, 2	R	1 = Male 2 = Female
31Ø-CA	Patient First Name		S	Used in processing to Twins
311-CB	Patient Last Name		S	
3Ø7-C7	Patient Location	0 = Not Specified 1 = Home 2 = Inter-Care 3 = Nursing Home 4 = Long Term/Extended Care 5 = Rest Home 6 = Boarding Home 7 = Skilled Care Facility 8 = Sub-Acute Care Facility 9 = Acute Care Facility 10 = Outpatient 11 - Hospice	R	For LTC Providers Only

<b>Transaction CLAIM SEGMENT</b>		<b>MANDATORY for B1, B2, and B3</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	Rx Billing
4Ø2-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	Ø3	M	NDC
4Ø7-D7	Product/Service ID		M	NDC
442-E7	Quantity Dispense		R	
4Ø3-D3	Fill Number		R	Ø = New
4Ø5-D5	Days Supply		R	
4Ø6-D6	Compound Code	Ø, 2	S	Ø = Not specified 2 = Compound
4Ø8-D8	Dispense as Written (DAW) Code	Ø, 1, 2, 3, 4, 5, 6, 7, 8, 9	S	Ø – No product selection indicated 1 – Substitution not allowed by Prescriber 2 – Substitution allowed – patient request brand 3 – Substitution allowed – Pharmacist selected product dispensed 4 – Substitution allowed-generics drug not in stock 5 – Substitution allowed – brand drug dispensed as generic 6 – override 7 – Substitution not allowed – brand drug mandated by law 8 – Substitution allowed – generic drug not available in mkt 9 – other
414-DE	Date Prescription Written	Format = CCYYMMDD	R	
415-DF	Number of Refills Authorized		R	
419-DJ	Prescription Origin Code		S	
42Ø-DK	Submissions Clarification Code		S	
3Ø8-C8	Other Coverage Code	ØØ, Ø1, Ø2, Ø3, Ø4, Ø5, Ø6, Ø7, Ø8	S	Required for COB processing Requires that the COB Segment be sent.
418-DI	Level of Service	0 = Not Specified 1 = Patient consultation 2 = Home delivery 3 = Emergency 4 = 24 hour service 5 = Patient consultation regarding generic product selection 6 = In-home service	S	
461-EU	Prior Authorization Type Code		S	
462-EV	Prior Authorization Number Submitted		S	
343-HD	Dispensing Status		S	Partial Fill not supported at this time; <future date>

<b>Transaction PHARMACY SEGMENT</b>		<b>NOT REQUIRED</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø2	M	Pharmacy Provider Segment

<b>Transaction PRESCRIBER SEGMENT</b>		<b>REQUIRED for B1 and B3</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01 – NPI 12 –DEA	M	<b>Effective May 23, 2007 the Prescriber ID Qualifier will be mandatory for all claims submissions</b>
411-DB	Prescriber ID		M	<b>Either the DEA or NPI will be accepted after May 23, 2007.</b>
468-2E	Primary Care Provider ID Qualifier		S	
421-DL	Primary Care Provider ID		S	

<b>Transaction COB/OTHER PAYMENT SEGMENT</b>		<b>REQUIRED FOR COB PROCESSING; EFFECTIVE 10/01/2004</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	1 – 3	M	If COB segment transmitted.
338-5C	Other Payer Coverage Type	Blank = Not specified 01 = Primary 02 = Secondary 03 = Tertiary 98 = Coupon 99 = Not supported at this time.	M (repeating)	
341-HB	Other Payer Amount Paid Count	Max 1	RW	When Other Coverage CD = 2 or 4
342-HC	Other Payer Amount Paid Qualifier	07 = Drug Benefits OR 08 = Sum of all Reimbursements.	RW	When Other Coverage Cd = 2 or 4
431-DV	Other Payer Amount Paid		RW	When Other Coverage CD =2; Required and must be > 0; When other coverage Cd = 4; not required, must = 0 if submitted.

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<b>Transaction WORKERS' COMPENSATION SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
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Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	M	Workers' Compensation Segment

<b>Transaction DUR/PPS SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
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Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	M	DUR/PPS Segment
473-7E	DUR/PPS Code Counter	1		Must equal 1
440-E5	Professional Service Code	MA	RW	Must equal a value of "MA" when Incentive Amount Submitted is Sent.

<b>Transaction PRICING SEGMENT</b>		<b>MANDATORY for B1 and B3</b>		
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Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment
4Ø9-D9	Ingredient Cost Submitted		R	All Claims except COPAY ONLY BILLINGS (OthCvCd=8); (Can be included in a Copay Only Billing, However, must be 0)
412-DC	Dispensing Cost Submitted		R	All Claims except COPAY ONLY BILLINGS (OthCvCd=8); (Can be included in a Copay Only Billing, However, must be 0)
433-DX	Patient Paid Amount Submitted		R	
438-E3	Incentive Amount Submitted		R	Must be greater than zero when PPS Professional Service Code is submitted
479-H8	Other Amount Claimed Submitted Qualifier	99	RW	Copay Only Billing (OthCvCd=8)
480-H9	Other Amount Claimed Submitted		RW	Copay Only Billing (OthCvCd=8)
481-HA	Flat Sales Tax Amount Submitted		S	
426-DQ	Usual and Customary Charge		R	
43Ø-DU	Gross Amount Due		R	
423-DN	Basis of Cost Determination		S	

<b>Transaction COUPON SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
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<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	Ø9	M	Coupon Segment

<b>Transaction COMPOUND SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	1Ø	M	Compound Segment

<b>Transaction PRIOR AUTHORIZATION SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	12	M	Prior Authorization Segment

<b>Transaction CLINICAL SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	13	M	Clinical Segment

**\*\* ADDITIONAL INFORMATION FOR CLAIM BILLING SUBMISSIONS \*\***

<p>COB/Other Payments Segment</p>	<p>COB claims processing will be supported beginning 10/01/2004.</p> <ul style="list-style-type: none"> <li>• Current Implementation provides for the processing of secondary Claims.</li> <li>• Reimbursement will be the patient share resulting from the primary (other) insurance.</li> <li>• Billing for Contracted Rate of Secondary is NOT provided except when claim was not covered by the primary (other) insurance.</li> </ul> <p>Both methods will be supported:</p> <p><b>Bill other Payer Amount</b> (other coverage codes: 2,3,4,5,6 &amp; 7)</p> <ul style="list-style-type: none"> <li>• The pricing segment amounts must contain the allowed amounts from the Primary (other) insurance billing and the COB segment must contain the amount paid by the primary insurance. The amount reimbursed by the secondary insurance will be the submitted GROSS AMOUNT DUE <u>minus</u> OTHER PAYER AMOUNT PAID.</li> <li>• When billing secondary with Other Coverage Code 2 (other cov exists – payment collected):             <ul style="list-style-type: none"> <li>○ The COB Segment is required and Other Payer Amount Paid must be &gt; 0</li> <li>○ The amount reimbursed by the secondary insurance will be the submitted GROSS AMOUNT DUE <u>minus</u> OTHER PAYER AMOUNT PAID.</li> </ul> </li> <li>• When billing Secondary with Other Coverage Code 4 (other cov exists – payment not collected):             <ul style="list-style-type: none"> <li>○ The COB Segment is required, and must be submitted with Other Payer Amount Paid, the Other Payer Amount Paid must be zero ).</li> <li>○ The Amount reimbursed by the secondary insurance will be the submitted Gross Amount Due.</li> </ul> </li> <li>• When Billing secondary with Other Coverage Codes (3,5,6,7)             <ul style="list-style-type: none"> <li>○ The COB Segment is required.</li> <li>○ The amount reimbursed by the secondary insurance will be the CONTRACT RATES.</li> </ul> </li> </ul> <p><b>Bill COPAY Only</b> (Total Patient pay; Other Coverage Code : 8)</p> <ul style="list-style-type: none"> <li>• The COB Segment need not be submitted and will be ignored if so.</li> <li>• The entire amount paid by the patient from the primary billing must be submitted in the Other Amount claimed Submitted field (480-H9) with Other Amount Claimed Submitted Qualifier (479-H8) set to '99' (other).</li> <li>• Other prices such as ingredient cost and sales tax must be set to zeros if being submitted.</li> </ul>
<p>Vaccine Administration Processing</p>	<ul style="list-style-type: none"> <li>• The Product/Service ID (407-D7) must be for a covered Part D Vaccine.</li> <li>• The Incentive Amount Submitted (438-E3) must be greater than zero</li> <li>• The Professional Service Code (440-E5) of 'MA" is required.</li> <li>• If an Incentive Fee is sent without the Professional Service code of "Ma" – the claim will be rejected for NCPDP Reject Code E5</li> <li>• If the professional service code of "MA" is sent without a corresponding incentive fee the claim will be rejected with the NCPDP Reject Code E3.</li> </ul>

**\*\* OTHER TRANSACTION INFORMATION \*\***

**Reversals**

Maximum Number of Transactions Supported per transmission	1
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	6 months on-line then must contact PDM Call center for a manual reversal

**\*\* CERTIFICATION REQUIREMENTS \*\***

Does payer/processor require software certification? No

**\*\* Response Segment and field requirements:  
PAID (or Duplicate of PAID) Response:**

<i>Transaction HEADER SEGMENT</i>		<i>MANDATORY IN ALL CASES</i>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
1Ø2-A2	Version/Release Number	Same value as in request billing	M	
1Ø3-A3	Transaction Code	Same value as in request billing	M	
1Ø9-A9	Transaction Count	Same value as in request billing	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request billing	M	
2Ø1-B1	Service Provider ID	Same value as in request billing	M	
4Ø1-D1	Date of Service	Same value as in request billing	M	

<i>RESPONSE MESSAGE SEGMENT</i>		<i>OPTIONAL</i>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	2Ø = Response Message Segment	M	
5Ø4-F4	Message	Required when text is needed for clarification or details	S	

<i>RESPONSE INSURANCE SEGMENT</i>		<i>NOT REQUIRED ; POSSIBLE FUTURE USE</i>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	25 = Response Insurance Segment	M	

<i>RESPONSE STATUS SEGMENT</i>		<i>REQUIRED</i>		
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>M/R/RW</i>	<i>Comment</i>
111-AM	Segment Identification	21 = Response Status Segment	M	

112-AN	Transaction Response Status	P = Paid D = Duplicate	M	
503-F3	Authorization Number		S	PDM Assigned 14 character Authorization Number
510-FA	Reject Count		S	
511-FB	Reject Code		S**R**	Max 5
526-FQ	Additional Message Information		S	
549-7F	Help Desk Phone Number Qualifier	Ø3 = Processor/PBM	S	
550-8F	Help Desk Phone Number		S	

<b>RESPONSE CLAIM SEGMENT</b>		<b>OPTIONAL</b>		
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	22 = Response Claim Segment	M	
455-EM	Prescription/Service Reference Number qualifier	1 = RX Billing	M	
402-D2	Prescription/Service Reference Number		M	

<b>RESPONSE PRICING SEGMENT</b>		<b>OPTIONAL</b>		
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	23 = Response Pricing Segment	M	
505-F5	Patient Pay Amount		S	Returned when the processor determines that the patient has payment responsibility for part/all of the claim
506-F6	Ingredient Cost Paid		S	Required when this value is used to arrive at the final reimbursement.
507-F7	Dispensing Fee Paid		S	Required when this value is used to arrive at the final reimbursement
558-AW	Flat Sales Tax Amount Paid		S	
521-FL	Incentive Amount Paid		S	Required when this value is used to arrive at the final reimbursement
509-F9	Total Amount Paid		S	
522-FM	Basis of Reimbursement Determination		S	
523-FN	Amount attributed to Sales Tax		S	
512-FC	Accumulated Deductible Amount		S	
513-FD	Remaining Deductible Amount		S	
514-FE	Remaining Benefit Amount		S	
517-FH	Amount Applied to Periodic Deductible		S	
518-FI	Amount of Copay/Co-insurance		S	

519-FJ	Amount Attributed to Product Selection		S	
520-FK	Amount exceeding Periodic Benefit Maximum		S	

- Medicare Part D Drug Program: As part of the Medicare Part D drug Program, the primary program messaging design will reference field (526-FQ) with the generic savings info to the pharmacy when a brand drug is dispensed. The field (526-FQ) will note: "CMS estimated brand/generic difference: nnn.nn."
- In addition, the beneficiary with other payer coverage will be identified in fields (504-F4) and if needed (526-FQ). The eligibility information will not ever be split between the 2 fields. If the elig info can not be completed in the first message field without being split, it will move to the second message field (526-FQ). The TrOOP facilitator defined response is what is being followed.

<b>RESPONSE DUR/PPS SEGMENT</b>			<b>OPTIONAL</b>	
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	24 = Response DUR/PPS Segment	M	
567-J6	DUR/PPS Response Code Counter		S***R***	
439-E4	Reason For Service Code	DC=Drug-Disease DD=Drug-Drug Interaction HD=High Dose LD=Low Dose PA=Drug-age SX=Drug-Gender TD=Therapeutic	S***R***	
528-FS	Clinical Significance Code	Blank = Not Specified 1 = Major 2 = Moderate 3 = Minor	S***R***	
529-FT	Other Pharmacy Indicator	Ø = Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in same Chain 3 = Other Pharmacy	S***R***	
530-FU	Previous Date of Fill		S***R***	
531-FV	Quantity of Previous Fill		S***R***	
532-FW	Database Indicator	2 = Medispan	S***R***	
533-FX	Other Prescriber Indicator	Ø = Not Specified 1 = Same prescriber 2 = Other Prescriber	S***R***	
544-FY	DUR Free Text Message		S***R***	Required when text is needed for additional clarification.

<b>RESPONSE PRIOR AUTHORIZATION SEGMENT</b>			<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>	
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	25 = Response Prior Authorization Segment	M	

**\*\* Response Segment and field requirements:**

**REJECT Response:**

<b>Transaction HEADER SEGMENT</b>		<b>MANDATORY IN ALL CASES</b>		
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
1Ø2-A2	Version/Release Number	Same value as in request billing	M	
1Ø3-A3	Transaction Code	Same value as in request billing	M	
1Ø9-A9	Transaction Count	Same value as in request billing	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request billing	M	
2Ø1-B1	Service Provider ID	Same value as in request billing	M	
4Ø1-D1	Date of Service	Same value as in request billing	M	

<b>RESPONSE MESSAGE SEGMENT</b>		<b>OPTIONAL</b>		
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	2Ø = Response Message Segment	M	
5Ø4-F4	Message	Required when text is needed for clarification or details	S	

<b>RESPONSE INSURANCE SEGMENT</b>		<b>NOT REQUIRED ; POSSIBLE FUTURE USE</b>		
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	25 = Response Insurance Segment	M	

<b>RESPONSE STATUS SEGMENT</b>		<b>REQUIRED</b>		
<b>Field #</b>	<b>NCPDP Field Name</b>	<b>Value</b>	<b>M/R/RW</b>	<b>Comment</b>
111-AM	Segment Identification	21 = Response Status Segment	M	
112-AN	Transaction Response Status	R = Rejected	M	
5Ø3-F3	Authorization Number		S	PDM Assigned 14 character Authorization Number
51Ø-FA	Reject Count		S	
511-FB	Reject Code		S**R**	Max 5
526-FQ	Additional Message Information		S	
549-7F	Help Desk Phone Number Qualifier	Ø3 = PBM/Processor	S	
55Ø-8F	Help Desk Phone Number		S	