Elixir Request For Pricing D.Ø Payer Sheet

General Information

Payer Name: ELIXIR	Revision Date: 9/1/2020	
Plan Name/Group Name: GAN020, GAN025, GAN030, GAN035, GAN060, RFP005, RFP010, RFP015, RFP025, RFP030, RFP050	BIN: ØØ9893	PCN: ROIRX
Processor: ELIXIR		
Effective as of: 9/1/2020	NCPDP Telecommunication Version/Release #: D.Ø	Transaction Code: B1 & B2
Contact/Information Source: elixirsolutions.com Pharmacy Help Desk Phone:1-800-361-4542		

Billing Transaction \ Segments and Fields

The following lists the segments available in a Billing Transaction. The document also lists values as defined under Version D.Ø. The Transaction Header Segment is mandatory. The Segment Summaries included below list the mandatory data fields.

M=Mandatory - The Field is mandatory for the Segment in the designated transaction.

R=Required - The Field has been designated with the situation of "Required" for the segment in the designated Transaction.

O=Optional / S= Situational - The situations designated have qualifications for usage

Other Transaction Information

Maximum Number of Transactions Supported per transmission	4
Reversal Window	9Ø days old
COB Processing	NCPDP Option 2 (OPPRA) ** Indicates Government entity requiring NCPDP COB processing Option 3; See General Information, Plan and Group listing for applicable Group Number, BIN and PCN combinations

Certification Requirements

Certification is not required.

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
1Ø1-A1	BIN Number			
		ØØ9893	M	
1Ø2-A2	Version/Release Number	D.Ø	M	
1Ø3-A3	Transaction Code	B1 or B2	M	
1Ø4-A4	Processor Control Number			
		ROIRX	M	
1Ø9-A9	Transaction Count	1-4	M	Maximum of 4 transactions per transmission
2Ø2-B2	Service Provider ID Qualifier	Ø1	M	
2Ø1-B1	Service Provider ID		M	NPI REQUIRED
4Ø1-D1	Date of Service		M	CCYYMMDD
11Ø-AK	Software Vendor/Certification ID		S	

Patient Segment: Mandatory

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø1	M	
331-CX	Patient ID Qualifier		O	
332-CY	Patient ID		O	
3Ø4-C4	Date of Birth		R	CCYYMMDD
3Ø5-C5	Patient Gender Code		R	1- MALE 2- FEMALE
3Ø7-C7	Place of Service		O	
31Ø-CA	Patient First Name		R	
311-CB	Patient Last Name		R	
322-CM	Patient Street Address		R	
323-CN	Patient City Address		R	
324-CO	Patient State/Province Address		R	Must be valid two character alphabetic state code

325-CP	Patient Zip/Postal Zone		R	The ZIP code must be a valid 5 or 9 digit USPS ZIP code and must not include hyphens or all zeros in 6th through 9th positions.
326-CQ	Patient Phone No.		O	If present, must be 1Ø digit numeric
333-CZ	Employer ID		O	
335-2C	Pregnancy Indicator		O	If present, valid values = null, 1,2
35Ø-HN	Patient Email Address		O	
384-4X	Patient Residence		R	

Pharmacy Provider Segment: Mandatory

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø2	M	
465-EY	Provider ID Qualifier		M	Valid value = Ø5
444-E9	Provider ID		M	Must be valid NPI

Prescriber Segment: Required

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø3	M	
466-EZ	Prescriber ID Qualifier	Ø1	R	Ø1 – National Provider Identifier (NPI)
411-DB	Prescriber ID		R	NPI (prescribing physician) must be 1Ø digits
427-DR	Prescriber Last Name		O	
498-PM	Prescriber Phone Number		O	If present, must be 1Ø digit numeric
468-2E	Primary Care Provider ID	Ø1	O	If present, value must = Ø1
421-DL	Primary Care Provider ID		O	Must be valid NPI If 468-2E is present and =Ø1
47Ø-4E	Primary Care Provider Last		O	
364-2J	Prescriber First Name		O	
365-2K	Prescriber Street Address		O	
366-2M	Prescriber City Address		O	
367-2N	Prescriber State/Providence Address		O	If present, must be valid two character alphabetic state code

368-2P	Prescriber Zip/Postal Zone		O	If 368-2P is present, ZIP code must be a valid 5 or 9 digit USPS ZIP code, must not include hyphens or all zeros in 6th through 9th positions.

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø4	M	
3Ø2-C2	Cardholder ID		M	
312-CC	Cardholder First Name		R	
313-CD	Cardholder Last Name		R	
314-CE	Home Plan		O	
524-FO	Plan ID		O	
3Ø9-C9	Eligibility Clarification Code		O	
336-8C	Facility ID		O	
3Ø1-C1	Group ID		R	
3Ø3-C3	Person Code		R	ALL (with noted exceptions)
3Ø6-C6	Patient Relationship Code		R	All Medicare Part D are Cardholders
36Ø-2B	Medicaid Indicator		O	Must be present with valid ST codes
361-2D	Provider Accept Assignment Indicator	Y, N	R	Must be present and = Y or N
997-G2	CMS Part D Defined Qualified Facility	Y, N	O	If present, must = Y or N
115-N5	Medicaid ID Number		R	
116-N6	Medicare Agency Number		R	

Claim Segment: Required

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø7	M	
455-EM	Prescription/Service Ref No. Qualifier	1	M	Must = 1
4Ø2-D2	Prescription/Service Ref No.		M	Max 12 digits
436-E1	Product/Service ID Qualifier	ØØ,Ø3	M	ØØ if Compound Code in 4Ø6-D6 = 2

4Ø7-D7	Product/Service ID		M	NDC; If 436-E1 = ØØ then must submit Ø NDC NDC NDC
456-EN	Associated Prescription/Service Ref No.		S	Must be present if 343-HD = "C"
457-EP	Associated Prescription/Serv. Date		S	CCYYMMDD / Must be present if 343-HD = "C" and 456-EN is present
458-SE	Procedure Modifier Code Count	1-1Ø	S	If present, must = total # of group occurrences
459-ER	Procedure Modifier Code		S	Must be present if 459-ER
442-E7	Quantity Dispensed		M	Must be present and > Ø
4Ø3-D3	Fill Number	Ø,1-99	R	The values defined for this field are Ø = Original fill, 1-99 = refill
4Ø5-D5	Days Supply		M	Must be present and > Ø
4Ø6-D6	Compound Code	1,2	R	1=Not a Compound, 2=Compound, If 2 is submitted, then compound segment is required.
4Ø8-D8	DAW / Prod Selection Code	Ø-5,7,9	R	6,8 Not allowed
414-DE	Date Prescription Written		M	CCYYMMDD
415-DF	Number of Refills Authorized		O	If present, must = Ø,1- 99
419-DJ	Prescription Origin Code	1-5	M	1=Written, 2=Telephonic, 3=Electronic, 4=Facsimile, 5=Pharmacy
354-NX	Submission Clarification Code Count	1-3	S	Must be present if 42Ø -DK is used
42Ø-DK	Submission Clarification Code		S	If 384-4X = 3,4,6,9 or 11 then 42Ø-DK must be 16 or 21-36*Per CMS mandate effective 2/28/13
	Left blank intentionally			
	Left blank intentionally			
	Left blank intentionally			

Claim Segment: Required (cont.)

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
3Ø8-C8	Other Coverage Code	ØØ, Ø1, Ø2, Ø3, Ø4, Ø8	R	If 3Ø8-C8 = Ø2, Ø3, Ø4, Ø8, COB segment** must be submitted
429-DT	Special Packaging Indicator		O	If present, values accepted are 'Ø-5'
453-EJ	Orig Prescribed Prod/Serv ID Qualifier	Ø3	O	Must be present if 455-EA is used
445-EA	Orig Prescribed Prod/Serv Code		O	Must be present if 453-EJ is used
446-EB	Originally Prescribed Quantity		O	
6ØØ-28	Unit of Measure		S	If present. Must be EA,GM.ML
418-DI	Level of Service		S	If present, must be Ø,1-6
461-EU	Prior Authorization Type Code		O	May be Required if Submitting Prior Auth
462-EV	Prior Authorization No. Submitted		O	May be Required if Submitting Prior Auth – not in either
463-EW	Intermediary Authorization Type ID		O	
464-EX	Intermediary Authorization ID		O	
343-HD	Dispensing Status	P, C	R	If present, P= Partial, C= Completion
344-HF	Quantity Intended to be Dispensed		S	Must be present and > Ø if 343-HD = P or C
345-HG	Days Supply Intended to be Dispensed		S	Must be present and > Ø if 343-HD = P or C
357-NV	Delay Reason Code		O	
391-MT	Patient Assignment Indicator	Y,N	R	Must be present and Y or N
995-E2	Route of Administration		S	
996-G1	Compound Type		O	
147-U7	Pharmacy Service Type		S	

Workers' Compensation Segment: Optional

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø6	M	
434-DY	Date of Injury		M	CCYYMMDD
315-CF	Employer Name		O	
316-CG	Employer Street Address		O	
317-CH	Employer City Address		O	
318-CI	Employer State/Province Address		O	
319-CJ	Employer Zip/Postal Zone		O	The ZIP code must be a valid 5 or 9 digit USPS ZIP code and must not include hyphens or all zeros in 6th through 9th positions.
32Ø-CK	Employer Phone Number		O	
321-CL	Employer Contact Name		O	
327-CR	Carrier ID		O	
435-DZ	Claim Reference/ID		R	
117-TR	Billing Entity Type Indicator		R	
118-TS	Pay To Qualifier		R	
119-TT	Pay To ID		O	
12Ø-TU	Pay To Name		O	
121-TV	Pay To Street Address		O	
122-TW	Pay To City		O	
123-TX	Pay To State/Province Address		O	
124-TY	Pay To Zip/Postal Zone		O	
125-TZ	Generic Equivalent Product ID Qualifier		O	
126-UA	Generic Equivalent Product ID		O	

COB/Other Payments Segment: Situational
***Required when other insurance processing is involved**

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø5	M	
337-4C	Coordination of Benefits/Other Payments Count	1-9	M	Must = total # of group occurrences that follow
338-5C	Other Payer Coverage Type		M	Must be present with values = Ø1- Ø9
339-6C	Other Payer ID Qualifier		R	If 338-5C is populated then values = Ø1, Ø2, Ø3,Ø4, Ø5, 1C, 1D, 99
34Ø-7C	Other Payer ID		R	Must be populated with Other Payer ID
443-E8	Other Payer Date		S	CCYYMMDD
341-HB	Other Payer Amount Paid Count	1-9	S	If present, must be = total # of group occurrences, 342-HC and 431-DV
342-HC	Other Payer Amount Paid Qualifier		S	If present, must be values = Ø1-Ø7, Ø9, 1Ø when 341-HB is used
431-DV	Other Payer Amount Paid		S	**Must be present for Government COB Processing
471-5E	Other Payer Reject Count		S	Must be present when 472-6E is used
472-6E	Other Payer Reject Code		S	Values are = ECL Appendix 1; Must be present when 3Ø8-C8 = 3
993-A7	Internal Control Number		S	
353-NR	Other Payer- Patient Responsibility Amount Count	1-25	S	Required if 3Ø8-C8 = Ø2** or Ø8. Required is 351-NP is populated
351-NP	Other Payer- Patient Responsibility Amount Qualifier		S	Required if 3Ø8-C8 = Ø2** or Ø8. If present, must =, Ø1-13, must be
352-NQ	Other Payer- Patient Responsibility Amount		S	Required if 3Ø8-C8 = Ø2** or Ø8. Required if 351-NP is populated .
392-MU	Benefit Stage Count	1-4	S	If present, must = total # of group occurrences that follow, 393-MV, 394-MW, must be present when 394-MW is used

393-MV	Benefit Stage Qualifier	Ø1, Ø2, Ø3, Ø4, 5Ø, 61, 62, 7Ø, 8Ø, 9Ø	S	Must be present when 394-MW is used
394-MW	Benefit Stage Amount		S	Must be present when 393-MV is used

DUR/PPS Segment: Required

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø8	M	
473-7E	DUR / PPS Code Counter	1-9	R	Submitted when requested by processor
439-E4	Reason for Service Code		R	Submitted when requested by processor
44Ø-E5	Professional Service Code		R	Submit MA when provider billing Vaccine Admin Fees
441-E6	Result of Service Code		R	Submitted when requested by processor
474-8E	DUR/PPS Level of Effort		O	
475-J9	DUR Co-Agent ID Qualifier		O	
476-H6	DUR Co-Agent ID		O	

Compound Segment: Optional
***Required when submitting a compound formulation with multiple active ingredients**

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	1Ø	M	If 4Ø6-D6 = 2, then segment is required
45Ø-EF	Compound Dosage Form Description Code		M	
451-EG	Compound Dispensing Unit Form Indicator		M	
447-EC	Compound Ingredient		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		M	Must be present
49Ø-UE	Compound Ingredient Basis of Cost Determination		R	
362-2G	Compound Ingredient Modifier Count		S	
363-2H	Compound Ingredient Modifier		S	

Coupon Segment: Optional

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	Ø9	M	
485-KE	Coupon Type		O	
486-ME	Coupon Number		O	
487-NE	Coupon Value Amount		O	

Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	11	M	
4Ø9-D9	Ingredient Cost Submitted		M	Must be present
412-DC	Dispensing Fee Submitted		R	
438-E3	Incentive Amount Submitted		S	Incentive Amount used when billing Vaccine Admin Fees. Enter Vaccine Admin Fee amount provider is billing. Field 44Ø-E5 MUST also be populated for claim to pay
478-H7	Other Amount Claimed Submitted Count		O	
479-H8	Other Amount Claimed Submitted Qualifier		O	
48Ø-H9	Other Amount Claimed Submitted		O	
481-HA	Flat Sales Tax Amount Submitted		O	

482-GE	Percentage Sales Tax Amount Submitted		O	
483-HE	Percentage Sales Tax Rate Submitted		O	
484-JE	Percentage Sales Tax Basis Submitted		O	
426-DQ	Usual and Customary Charge		M	
43Ø-DU	Gross Amount Due		O	
423-DN	Basis of Cost Determination		O	

Clinical Segment: Required

Field #	NCPDP Field Name	Value	Payer Usage	Requirements/Values
111-AM	Segment Identification	13	M	
491-VE	Diagnosis Code Count	1-9	O	
492-WE	Diagnosis Code Qualifier		O	
424-DO	Diagnosis Code		O	
493-XE	Clinical Information Counter		O	
494-ZE	Measurement Date		O	CCYYMMDD
495-H1	Measurement Time		O	HHMM
496-H2	Measurement Dimension		O	
497-H3	Measurement Unit		O	
499-H4	Measurement Value		O	

Additional Information:

Zip Codes:
If the zip code is 98765-4321, this field would reflect: 987654321.
If the zip code is 98765, this field would reflect: 98765 left justified