North Carolina Medicaid Direct NCPDP D.0 Payer Specifications Claim Billing

March 2, 2026

Claim Billing Payer Sheet

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

General Information

Payer Name: Prime Therapeutics State Government Solutions LLC (Prime)		
Plan Names/Group Name: NC Medicaid Direct	**BIN**: 610242	**PCN:** 781640064
Effective as of: May 2, 2026	**NCPDP Telecommunication Standard Version/Release #**: D.0	
NCPDP Data Dictionary Version Date: October 2025	**NCPDP External Code List Version Date**: October 2025	
Pharmacy Help Desk Information: 844-620-6116		

Transactions Supported

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Rebill
E1	Eligibility Transaction

Field Legend for Columns

Fields that are not used in the Claim Billing transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when." The situations designated have qualifications for usage ("Required if x," "Not required if y").	Yes

Claim Billing

The following lists the segments and fields in a Claim Billing Transaction for the *NCPDP Telecommunication Standard Implementation Guide Version D.0.*

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 (110-AK) is Payer Issued.	X	Required when vendor certification is required by Prime – otherwise submit all zeroes.

Transaction Header Segment		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN Number	610242	M	
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B1, B3	M	
104-A4	Processor Control Number	781640064	M	
109-A9	Transaction Count		M	One transaction for compound claims; Up to 4 transactions allowed for B1 or B3.
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID		M	National Provider Identifier (NPI) of submitting pharmacy provider
401-D1	Date of Service		M	
110-AK	Software Vendor/Certification ID	This will be supplied by the provider's software vendor.	M	Submit ID or all zeroes.

Insurance Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent.	X	

Insurance Segment Identification (111-AM) = "04"		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	Cardholder ID		M	10 Digits (nine numeric digits and one alphabetic character)

Insurance Segment Segment Identification (111-AM) = "04"		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
301-C1	Group ID		RW	Leave blank; **Do Not Send**
312-CC	Cardholder First Name		R	
313-CD	Cardholder Last Name		R	

Patient Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent.	X	

Patient Segment Segment Identification (111-AM) = "01"		Claim Billing/Claim Rebill		
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	Date of Birth		R	
305-C5	Patient Gender Code		R	
310-CA	Patient First Name		R	
311-CB	Patient Last Name		R	
307-C7	Place of Service		RW	Required if this field could result in different coverage, pricing or patient financial responsibility. NCDHHS will source all data from the Patient Residence field.
384-4X	Patient Residence	0 = Not Specified 2 = Skilled Nursing Facility 3 = Nursing Facility 9 = Intermediate Care Facility/Individuals with Intellectual Disabilities	RW	Use 2, 3 or 9 to identify Long-Term Care (LTC) Beneficiaries. Field is required only when residence results in different coverage, pricing or patient financial responsibility.
335-2C	Pregnancy Indicator	Blank = Not Specified 1 = Not Pregnant 2 = Pregnant	RW	Required only if pregnancy could result in different coverage, pricing or patient financial responsibility.

Claim Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent.	X	
This plan does not support partial fills.	X	

Claim Segment Segment Identification (111-AM) = "07"		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier		M	
407-D7	Product/Service ID		M	
442-E7	Quantity Dispensed		R	
460-ET	Quantity Prescribed		RW	Required when transmitting Schedule II drugs as defined in 21 CFR 1308.12 and per CMS-005-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document).
403-D3	Fill Number		R	
405-D5	Days' Supply		R	
406-D6	Compound Code	1 = Not A Compound 2 = Compound	R	
408-D8	Dispense as Written (DAW)/Product Selection Code		R	NCDHHS requires a valid value to process a claim.
414-DE	Date Prescription Written		R	
415-DF	Number of Refills Authorized	0 = No Refills Authorized 1-99 = Authorized Refill Number	R	Required to identify the number of refills authorized by the prescriber.
419-DJ	Prescription Origin Code		R	Required for all claims per NCPDP standards

Claim Segment Segment Identification (111-AM) = "07"		Claim Billing/Claim Rebill		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
354-NX	Submission Clarification Code Count	Maximum count of 3	RW	Required if Submission Clarification Code (420-DK) is used.
420-DK	Submission Clarification Code	00 = Not Specified 02 = Other Override 03 = Vacation Supply 04 = Lost Prescription 05 = Therapy Change 08 = Process Compound for Approved Ingredients 10 = Meets Plan Limitations 11 = Certification on File 13 = Emergency/Disaster Situation (<mark>NEW</mark>) 18 = LTC Patient Admit/Readmit 20 = 340B Provider 99 = Other	RW	• **Submit "2"** for beneficiary ages 18 and older for an atypical antipsychotic or 2nd generation antipsychotic is rejecting for **NCPDP 75 – Prior Authorization Required.** *Submission indicates that pharmacy provider has confirmed PA criteria are met.* • **Submit "3"** for early refill to indicate a vacation supply. • **Submit "4"** for early refill to indicate lost medication. • **Submit "5"** for early refill to indicate a therapy change. • **Submit "8"** for compound claims containing both covered and non-covered ingredients to allow reimbursement of covered ingredients only. • **Submit "10"** for a behavioral health drug exceeds a dose limit. *Submission indicates the pharmacy has confirmed the dose.* • **Submit "11"** for beneficiary > 18 for an atypical antipsychotic or 2nd generation antipsychotic is rejecting for **NCPDP 75 – Prior**

Claim Segment Segment Identification (111-AM) = "07"		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Authorization Required. *Submission indicates that pharmacy provider has confirmed PA criteria are met.* • **Submit "13"** when a State of Emergency has been declared. • **Submit "18"** for early refill to indicate a beneficiary entering or re-entering an LTC facility. • **Submit "20"** when billing a 340B claim for drugs purchased under Section 340B of the Public Health Service Act. • **Submit "99"** when billing a 340B claim for a new 340B pharmacy not listed in the Medicaid Exclusion File on the claim date of service. **Note:** Claims submitted with Submission Clarification Codes (SCC): 3, 4, 5, 13 or 18 that reject for early refill must also include applicable Drug Utilization Review (DUR) codes to continue through adjudication.
308-C8	Other Coverage Code	00 = Not Specified 01 = No Other Coverage Identified 02 = Other Coverage Exists – Payment Collected 03 = Other Coverage Exists – Claim Not Covered 04 = Other Coverage Exists – Payment Not Collected	RW	Required for Coordination of Benefits (COB) when other insurance coverage exists. .
600-28	Unit of Measure	EA = Each GM = Grams	R	

Claim Segment Segment Identification (111-AM) = "07"		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		ML = Milliliters		
418-DI	Level of Service	2 = Home Delivery 3 = Emergency 6 = In-Home Service	RW	Required if this field could result in different coverage, pricing or patient financial responsibility.
461-EU	Prior Authorization Type Code	0 = Not Specified 1 = Prior Authorization 4 = Exemption from Copay and/or Coinsurance 9 = Emergency Preparedness	RW	Required if this field could result in different coverage, pricing or patient financial responsibility.
462-EV	Prior Authorization Number Submitted		RW	Required if this field could result in different coverage, pricing or patient financial responsibility.
995-E2	Route of Administration	SNO-MED	RW	Required when Compound Code (406-D6) = 2 (Compound)
996-G1	Compound Type		RW	

Pricing Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent.	X	

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
409-D9	Ingredient Cost Submitted		R	
412-DC	Dispensing Fee Submitted		RW	Required if its value affects the Gross Amount Due (430-DU) calculation.
433-DX	Patient Paid Amount Submitted		RW	**NOT REQUIRED; DO NOT SEND**
426-DQ	Usual and Customary Charge		R	
430-DU	Gross Amount Due		R	
423-DN	Basis of Cost Determination	00 = Not Specified 08 = 340B/Disproportionate Share Pricing/Public Health Service	RW	• **Submit "08"** when billing a 340B claim for drugs purchased under Section 340B of the Public Health Service Act.

Pricing Segment Segment Identification (111-AM) = "11"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Required if needed for receiver claim/encounter adjudication.

Prescriber Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent.	X	

Prescriber Segment Segment Identification (111-AM) = "03"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	Prescriber ID Qualifier	01 = NPI	R	Required if Prescriber ID (411-DB) is used. *Payer Requirement:* NCDHHS requires the NPI qualifier.
411-DB	Prescriber ID	Prescriber's Individual NPI	R	A valid NPI must be submitted.

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is always sent when applicable.		
This Segment is situational.	X	Required only for secondary, tertiary, etc. claims.
Scenario 3 – Other Payer Amount Paid, Other Payer – Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"		Claim Billing Scenario 3 – Other Payer Amount Paid, Other Payer – Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 9 occurrences	M	
338-5C	Other Payer Coverage Type		M	
339-6C	Other Payer ID Qualifier		RW	Required if Other Payer ID (340-7C) is used.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"		Claim Billing Scenario 3 – Other Payer Amount Paid, Other Payer – Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
340-7C	Other Payer ID		RW	Required when another payer has adjudicated the claim.
443-E8	Other Payer Date		RW	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	Other Payer Amount Paid Count	Maximum count of 9 occurrences	RW	Required if Other Payer Amount Paid Qualifier (342-HC) is used. Required when another payer has adjudicated the claim.
342-HC	Other Payer Amount Paid Qualifier		RW	Required if Other Payer Amount Paid (431-DV) is used. Required when another payer has adjudicated this claim.
431-DV	Other Payer Amount Paid		RW	Required if other payer has approved payment for some/all of the billing. Not used for patient responsibility only billing.
471-5E	Other Payer Reject Count	Maximum of 5 occurrences	RW	Required if Other Payer Reject Code (472-6E) is used.
472-6E	Other Payer Reject Code		RW	Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – Claim Not Covered).
353-NR	Other Payer – Patient Responsibility Amount Count	Maximum Count of 25 occurrences	RW	Required if Other Payer-Patient Responsibility

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"		Claim Billing Scenario 3 – Other Payer Amount Paid, Other Payer – Patient Responsibility Amount and Benefit Stage Repetitions Present (Government Programs)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Amount Qualifier (351-NP) is used.
351-NP	Other Payer – Patient Responsibility Amount Qualifier	05 – Amount of Copay 06 – Patient Pay Amount 07 – Amount of Coinsurance	RW	Required when Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	Other Payer – Patient Responsibility Amount		RW	Required if necessary for patient financial responsibility only billing.

DUR/PPS Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is situational.	X	Submitted if required to affect outcome of claim related to DUR intervention.

DUR/PPS Segment Segment Identification (111-AM) = "08"		Claim Billing		
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 when there is a conflict to resolve or reason for service to be explained.
440-E5	Professional Service Code	M0 = Prescriber Consulted P0 = Patient Consulted R0 = Pharmacist Consulted Other Source 00 = No Intervention Blank = Not Specified	RW	Required when there is a professional service to be identified.
441-E6	Result of Service Code	1A = Filled, False Positive 1B = Filled Prescription As Is	RW	Required when there is a result of service to be submitted.

Prime THERAPEUTICS™

DUR/PPS Segment Segment Identification (111-AM) = "08"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
		1C = Filled with different dose		
		1D = Filled with different directions		
		1E = Filled with different drug		
		1F = Filled with different quantity		
		1G = Filled with prescriber approval		
		2A = Prescription Not Filled		
		2B = Prescription Not Filled – Directions Clarified		
474-8E	DUR/PPS Level of Effort		RW	Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is situational.	X	Submitted if the claim dispensed is a compound.

Compound Segment Segment Identification (111-AM) = "10"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
450-EF	Compound Dosage Form Description Code		M	
451-EG	Compound Dispensing Unit Form Indicator		M	
447-EC	Compound Ingredient Component Count	2 to 25	M	At least 2 ingredients, up to a maximum of 25 ingredients
488-RE	Compound Product ID Qualifier		M	
489-TE	Compound Product ID		M	
448-ED	Compound Ingredient Quantity		M	

Compound Segment Segment Identification (111-AM) = "10"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
449-EE	Compound Ingredient Drug Cost		R	Enter the ingredient drug cost.
490-UE	Compound Ingredient Basis of Cost Determination		RW	Required if needed for receiver claim determination when multiple products are billed.

Clinical Segment Questions	Check	Claim Billing If Situational, Payer Situation
This Segment is situational.	X	

Clinical Segment Segment Identification (111-AM) = "13"		Claim Billing		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
491-VE	Diagnosis Code Count	Maximum count of 5 occurrences	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	Diagnosis Code Qualifier	02 – ICD10	RW	Required if Diagnosis Code (424-DO) is used.
424-DO	Diagnosis Code		RW	Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs.

End of Request Claim Billing (B1) Payer Sheet

Response Claim Billing/Claim Rebill Payer Sheet

Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) Response

Start of Response Claim Billing (B1)/Claim Rebill (B3) Payer Sheet

General Information

Payer Name: Prime Therapeutics State Government Solutions LLC		
Plan Names/Group Name: North Carolina Medicaid Direct	BIN: 610242	PCN: 781640064

Claim Billing/Claim Rebill PAID (or Duplicate of PAID) Response

The following lists the segments and fields in a Claim Billing response (Paid or Duplicate of Paid) Transaction for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*.

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent.	X	

Response Transaction Header Segment		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is situational.	X	Sent if additional information is available from the payer/processor.

Response Message Segment Segment Identification (111-AM) = "20"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		R	*Imp Guide:* Required if text is needed for clarification or detail

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is situational.	X	

Response Insurance Segment Segment Identification (111-AM) = "25"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
524-FO	Plan ID		RW	
301-C1	Group ID		RW	
302-C2	Cardholder ID		RW	

Response Patient Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is situational.	X	

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	Patient First Name		RW	
311-CB	Patient Last Name		RW	
304-C4	Date of Birth		RW	

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	P = Paid D = Duplicate of Paid	M	
503-F3	Authorization Number		RW	Required if needed to identify the transaction.

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
547-5F	Approved Message Code Count	Maximum count = 5 occurrences	RW	Required if Approved Message Code (548-6F) is used.
548-6F	Approved Message Code		RW	Required if Approved Message Code Count (547- 5F) is used.
130-UF	Additional Message Information Count	Maximum count of 25 = occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used.
549-7F	Help Desk Phone Number Qualifier		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	Help Desk Phone Number		RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent.	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier	1 = RxBilling	M	
402-D2	Prescription/Service Reference Number		M	

Response Pricing Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is always sent.		

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
505-F5	Patient Pay Amount		R	
506-F6	Ingredient Cost Paid		R	
507-F7	Dispensing Fee Paid		RW	Required if this value is used to arrive at the final reimbursement.
521-FL	Incentive Amount Paid		RW	Required if Incentive Amount Submitted (438-E3) is greater than zero (0).
563-J2	Other Amount Paid Count		RW	Required if Other Amount Paid (565-J4) is used.
564-J3	Other Amount Paid Qualifier		RW	Required if Other Amount Paid (565-J4) is used.
565-J4	Other Amount Paid		RW	Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (0).
566-J5	Other Payer Amount Recognized			Required if Other Payer Amount Paid (431-DV) is greater than zero and Coordination of Benefits/Other Payments Segment is supported.
509-F9	Total Amount Paid		R	
522-FM	Basis of Reimbursement Determination		RW	Required if Ingredient Cost Paid (506-F6) is greater than zero (0). Required if Basis of Cost Determination (432-DN) is submitted on billing.

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is situational.	X	Sent when DUR intervention is encountered during claim processing.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS Response Code Counter	Maximum 9 occurrences supported	RW	Required if Reason for Service Code (439-E4) is used.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
439-E4	Reason for Service Code		RW	Required if utilization conflict is detected.
528-FS	Clinical Significance Code		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	Other Pharmacy Indicator		RW	Required if needed to supply additional information for the utilization conflict.
530-FU	Previous Date of Fill		RW	Required if Quantity of Previous Fill (531-FV) is used.
531-FV	Quantity of Previous Fill		RW	Required if Previous Date of Fill (530-FU) is used.
532-FW	Database Indicator		RW	Required if needed to supply additional information for the utilization conflict.
533-FX	Other Prescriber Indicator		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR Free Text Message		RW	Required if needed to supply additional information for the utilization conflict.
570-NS	DUR Additional Text		RW	Required if needed to supply additional information for the utilization conflict.

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, Payer Situation
This Segment is situational.	X	Sent when Other Health Insurance (OHI) is encountered during claims processing.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	Other Payer ID Count	Maximum count of 3 occurrences	M	
338-5C	Other Payer Coverage Type		M	
356-NU	Other Payer Cardholder ID		RW	Required if other insurance information is available for coordination of benefits.

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
339-6C	Other Payer ID Qualifier		RW	Required if Other Payer ID (340-7C) is used.
340-7C	Other Payer ID		RW	Required if other insurance information is available for coordination of benefits.
991-MH	Other Payer Processor Control Number		RW	Required if other insurance information is available for coordination of benefits.
992-MJ	Other Payer Group ID		RW	Required if other insurance information is available for coordination of benefits.
142-UV	Other Payer Person Code		RW	Required if needed to uniquely identify the family members within the cardholder ID, as assigned by the other payer.
127-UB	Other Payer Help Desk Phone Number		RW	Required if needed to provide a support telephone number of the other payer to the receiver.
143-UW	Other Payer Patient Relationship Code		RW	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.
144-UX	Other Payer Benefit Effective Date		RW	Required when other coverage is known, which is after the Date of Service submitted.
145-UY	Other Payer Benefit Termination Date		RW	Required when other coverage is known, which is after the Date of Service submitted.

Claim Billing/Claim Rebill Accepted/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Transaction Header Segment		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational.	X	

Response Message Segment Segment Identification (111-AM) = "20"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Insurance Segment Identification (111-AM) = "25"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
301-C1	Group ID		RW	

Response Insurance Segment Identification (111-AM) = "25"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
524-FO	Plan ID		RW	Required if needed to identify the actual plan parameters, benefit or coverage criteria when available.
568-J7	Payer ID Qualifier		RW	Required if Payer ID (569-J8) is used.
569-J8	Payer ID		RW	Required to identify the ID of the payer responding.
302-C2	Cardholder ID		RW	Required if the identification to be used in future transactions is different than what was submitted on the request.

Response Patient Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational.	X	Sent when known by plan

Response Patient Segment Segment Identification (111-AM) = "29"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
310-CA	Patient First Name		RW	Required if known.
311-CB	Patient Last Name		RW	Required if known.
304-C4	Date of Birth		RW	Required if known.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status		M	
503-F3	Authorization Number		RW	Required if needed to identify the transaction.
510-FA	Reject Count	Maximum count 5 occurrences	R	
511-FB	Reject Code		R	

Response Status Segment Identification (111-AM) = "21"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
546-4F	Reject Field Occurrence Indicator		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	Additional Message Information Count	Maximum count 25 occurrences	RW	Required if Additional Message Information (526- FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526- FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526- FQ) is used.
549-7F	Help Desk Phone Number Qualifier		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	Help Desk Phone Number		RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier		M	
402-D2	Prescription/Service Reference Number		M	

Response DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational.	X	Sent when DUR intervention is encountered during claim adjudication.

Response DUR/PPS Segment Segment Identification (111-AM) = "24"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
567-J6	DUR/PPS Response Code Counter	Maximum 9 occurrences supported	RW	Required if Reason for Service Code (439-E4) is used.
439-E4	Reason for Service Code		RW	Required if utilization conflict is detected.
528-FS	Clinical Significance Code		RW	Required if needed to supply additional information for the utilization conflict.
529-FT	Other Pharmacy Indicator		RW	Required if needed to supply additional information for the utilization conflict.
530-FU	Previous Date of Fill		RW	Required if Quantity of Previous Fill (531-FV) is used.
531-FV	Quantity of Previous Fill		RW	Required if Previous Date of Fill (530-FU) is used.
532-FW	Database Indicator		RW	Required if needed to supply additional information for the utilization conflict.
533-FX	Other Prescriber Indicator		RW	Required if needed to supply additional information for the utilization conflict.
544-FY	DUR Free Text Message		RW	Required if needed to supply additional information for the utilization conflict.
570-NS	DUR Additional Text		RW	Required if needed to supply additional information for the utilization conflict.

Response Prior Authorization Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational.	X	Sent when claim adjudication outcome requires subsequent PA number for payment

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, Payer Situation
This Segment is situational.	X	Sent when Other Health Insurance (OHI) is encountered during claim processing

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
355-NT	Other Payer ID Count	Maximum count of 3 occurrences	M	
338-5C	Other Payer Coverage Type		M	
339-6C	Other Payer ID Qualifier		RW	Required if Other Payer ID (340-7C) is used.
340-7C	Other Payer ID		RW	Required if other insurance information is available for coordination of benefits.
991-MH	Other Payer Processor Control Number		RW	Required if other insurance information is available for coordination of benefits.
356-NU	Other Payer Cardholder ID		RW	Required if other insurance information is available for coordination of benefits.
992-MJ	Other Payer Group ID		RW	Required if other insurance information is available for coordination of benefits.
142-UV	Other Payer Person Code		RW	Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.
127-UB	Other Payer Help Desk Phone Number		RW	Required if needed to provide a support telephone number of the other payer to the receiver.
143-UW	Other Payer Patient Relationship Code		RW	Required if needed to uniquely identify the relationship of the patient to the Cardholder ID,

Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"		Claim Billing/Claim Rebill Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				as assigned by the other payer.
144-UX	Other Payer Benefit Effective Date		RW	Required when other coverage is known, which is after the Date of Service submitted.
145-UY	Other Payer Benefit Termination Date		RW	Required when other coverage is known, which is after the Date of Service submitted.

Claim Billing Rejected/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Transaction Header Segment		Claim Billing/Claim Rebill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, Payer Situation
This Segment is situational.	X	

Response Message Segment Segment Identification (111-AM) = "20"		Claim Billing/Claim Rebill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Rejected/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Status Segment Identification (111-AM) = "21"		Claim Billing/Claim Rebill Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Reject	M	
503-F3	Authorization Number		RW	Required if needed to identify the transaction.
510-FA	Reject Count	Maximum count 5 occurrences	R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526FQ) is used.
549-7F	Help Desk Phone Number Qualifier		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	Help Desk Phone Number		RW	Required if needed to provide a support telephone number to the receiver.

** End of Response Claim Billing (B1/B3) Payer Sheet**

NCPDP Version D.0 Claim Reversal

Request Claim Reversal Payer Sheet

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

General Information

Payer Name: Prime Therapeutics State Government Solutions LLC	**Date:** May 2, 2026	
Plan Names/Group Name: North Carolina Medicaid Direct	**BIN:** 610242	**PCN:** 781640064

Claim Reversal Transaction

The following lists the segments and fields in a Claim Reversal Transaction for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*.

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 (110- AK) is Payer Issued	X	Required when vendor certification is required by (Prime) – otherwise submit all zeroes.

Transaction Header Segment		Claim Reversal		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
101-A1	BIN NUMBER	610242	M	
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B2	M	
104-A4	Processor Control Number	781640064	M	
109-A9	Transaction Count		M	
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID	NPI Number	M	
401-D1	Date of Service		M	
110-AK	Software Vendor/Certification ID		M	If no number is supplied, populate with zeroes.

Insurance Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent.	X	

Insurance Segment Segment Identification (111-AM) = "04"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	Cardholder ID		M	

Claim Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is always sent.	X	

Claim Segment Segment Identification (111-AM) = "07"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier	1 – Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	03 - NDC	M	
407-D7	Product/Service ID		M	
403-D3	Fill Number	0 = Original Dispensing 1–99 = Number of refills	RW	Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (402-D2) occur on the same day.
308-C8	Other Coverage Code		RW	Required if needed by receiver to match the claim that is being reversed.

Pricing Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is situational.	X	

Pricing Segment Segment Identification (111-AM) = "11"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
438-E3	Incentive Amount Submitted		RW	Required if this field could result in contractually agreed upon payment.
430-DU	Gross Amount Due		RW	Required if this field could result in contractually agreed upon payment.

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"		Claim Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 9 occurrences	M	
338-5C	Other Payer Coverage Type		M	
339-6C	Other Payer ID Qualifier		RW	Required if Other Payer ID (34Ø-7C) is used.
340-7C	Other Payer ID		RW	Required when another payer has adjudicated this claim.
443-E8	Other Payer Date		RW	Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.

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

Response Claim Reversal Payer Sheet Claim Reversal Accepted/Approved Response

** Start of Claim Reversal Response (B2) Payer Sheet**

General Information

Payer Name: Prime Therapeutics State Government Solutions LLC	Date: May 2, 2026	
Plan Names/Group Name: North Carolina Medicaid Direct	BIN: 610242	PCN: 781640064

Claim Reversal Accepted/Approved Response

The following lists the segments and fields in a Claim Reversal Response (Approved) Transaction for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*.

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent.	X	

Response Transaction Header Segment		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is situational.	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "20"		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	A = Approved	M	
503-F3	Authorization Number		RW	Required if needed to identify the transaction.
547-5F	Approved Message Code Count	Maximum count of 5 occurrences	RW	Required if Approved Message Code (548-6F) is used.
548-6F	Approved Message Code		RW	Required if Approved Message Code Count (547-5F) is used and the sender needs to communicate additional follow-up for a potential opportunity.
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.
549-7F	Help Desk Phone Number Qualifier		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	Help Desk Phone Number		RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is always sent.	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	

Response Pricing Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, Payer Situation
This Segment is situational.	X	Sent if reversal results in generation of pricing detail.

Response Pricing Segment Segment Identification (111-AM) = "23"		Claim Reversal – Accepted/Approved		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
521-FL	Incentive Amount Paid		RW	Required if this field is reporting a contractually agreed upon payment.
509-F9	Total Amount Paid		RW	Required if any other payment fields sent by the sender.

Claim Reversal Accepted/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Transaction Header Segment		Claim Reversal – Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B2	M	

Response Transaction Header Segment		Claim Reversal – Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation
This Segment is situational.	X	

Response Message Segment Segment Identification (111-AM) = "20"		Claim Reversal – Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal – Accepted/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Reject	M	
503-F3	Authorization Number		R	
510-FA	Reject Count	Maximum count of 5 occurrences	R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal – Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.
549-7F	Help Desk Phone Number Qualifier		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	Help Desk Phone Number		RW	Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	Check	Claim Reversal – Accepted/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Claim Segment Segment Identification (111-AM) = "22"		Claim Reversal – Accepted/Rejected		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
455-EM	Prescription/Service Reference Number Qualifier	1 = RxBilling	M	
402-D2	Prescription/Service Reference Number		M	

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Reversal If Situational, Payer Situation
This Segment is situational.	X	

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "05"		Claims Reversal		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 9 occurrences	M	
338-5C	Other Payer Coverage Type		M	

Claim Reversal Rejected/Rejected Response

Response Transaction Header Segment Questions	Check	Claim Reversal – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Transaction Header Segment		Claim Reversal – Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	B2	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	01 - NPI	M	
201-B1	Service Provider ID	NPI	M	
401-D1	Date of Service	Same value as in request	M	

Response Message Segment Questions	Check	Claim Reversal – Rejected/Rejected If Situational, Payer Situation
This Segment is situational.	X	

Response Message Segment Segment Identification (111-AM) = "20"		Claim Reversal – Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Claim Reversal – Rejected/Rejected If Situational, Payer Situation
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"		Claim Reversal – Rejected/Rejected		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Reject	M	
503-F3	Authorization Number		R	
510-FA	Reject Count	Maximum count of 5 occurrences	R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.
549-7F	Help Desk Phone Number Qualifier		RW	Required if Help Desk Phone Number (550-8F) is used.
550-8F	Help Desk Phone Number		RW	Required if needed to provide a support telephone number to the receiver.

** End of Claim Reversal (B2) Response Payer Sheet**

Eligibility Verification

Request Eligibility Verification Payer Sheet

General Information

Payer Name: Prime Therapeutics State Government Solutions LLC		**Date:** May 2, 2026	
Plan Names/Group Name: North Carolina Medicaid Direct		**BIN:** 610242	**PCN:** 781640064

Other Transactions Supported

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal
B3	Claim Rebill

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.	**No**
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	**No**
QUALIFIED REQUIREMENT	**RW**	"Required when." The situations designated have qualifications for usage ("Required if x," "Not required if y").	**Yes**

Eligibility Verification Transaction

The following lists the segments and fields in Eligibility Verification Transaction for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	Check	Eligibility Verification
This Segment is always sent.	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued.	X	

Transaction Header Segment		Eligibility Verification		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
101-A1	BIN Number	610242	M	
102-A2	Version/Release Number	D0	M	

Transaction Header Segment			Eligibility Verification	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
103-A3	Transaction Code	E1	M	
104-A4	Processor Control Number	781640064	M	
109-A9	Transaction Count	1 - One Occurrence	M	
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID		M	NPI of submitting pharmacy provider
401-D1	Date Of Service		M	
110-AK	Software Vendor/Certification ID		M	Submit ID or all zeroes.

Insurance Segment Questions	Check	Eligibility Verification
This Segment is always sent.	X	

Insurance Segment Segment Identification (111-AM) = "04"			Eligibility Verification	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
302-C2	Cardholder ID		M	

Patient Segment Questions	Check	Eligibility Verification
This Segment is always sent.	X	

Patient Segment Segment Identification (111-AM) = "01"			Eligibility Verification	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
304-C4	Date Of Birth		RW	Required if needed for receiver inquiry validation and/or determination. Required if necessary for state/federal/regulatory agency programs.
311-CB	Patient Last Name		R	

End of Request Eligibility Verification (E1) Payer Sheet

Eligibility Verification Response

Eligibility Verification Accepted/Approved Response

Start of Eligibility Verification Response (E1) Payer Sheet

General Information

Payer Name: Prime Therapeutics State Government Solutions LLC		**Date:** May 2, 2026	
Plan Names/Group Name: North Carolina Medicaid Direct / NCMEDICAID		**BIN:** 610242	**PCN:** 781640064

Eligibility Verification Accepted/Approved Response

The following lists the segments and fields in an Eligibility Verification Response (Approved) Transaction for the *NCPDP Telecommunication Standard Implementation Guide Version D.0*.

Response Status Segment Questions	Check	Eligibility Verification – Accepted/Approved
This Segment is always sent.	X	

Response Transaction Header Segment		Eligibility Verification – Accepted/Approved		
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	E1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date Of Service	Same value as in request	M	

Response Message Header Segment Questions	Check	Eligibility Verification – Accepted/Approved
This Segment is situational.	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "20"			Eligibility Verification – Accepted/Approved	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Eligibility Verification – Accepted/Approved
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification – Accepted/Approved	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	A = Approved	M	
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.

Eligibility Verification Accepted/Rejected Response

Response Transaction Header Segment Questions	Check	Eligibility Verification – Accepted/Rejected
This Segment is always sent.	X	

Response Transaction Header Segment			Eligibility Verification – Accepted/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
102-A2	Version/Release Number	D0	M	

Response Transaction Header Segment			Eligibility Verification – Accepted/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
103-A3	Transaction Code	E1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	A = Accepted	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date Of Service	Same value as in request	M	

Response Message Segment Questions	Check	Eligibility Verification – Accepted/Rejected
This Segment is situational.	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "20"			Eligibility Verification – Accepted/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Eligibility Verification – Accepted/Rejected
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification – Accepted/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Reject	M	

Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification – Accepted/Rejected	
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
510-FA	Reject Count	Maximum count of 5 occurrences	R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.

Response Transaction Header Segment Questions	Check	Eligibility Verification – Rejected/Rejected
This Segment is always sent.	X	

Response Transaction Header Segment			Eligibility Verification – Rejected/Rejected	
Field #	**NCPDP Field Name**	**Value**	**Payer Usage**	**Payer Situation**
102-A2	Version/Release Number	D0	M	
103-A3	Transaction Code	E1	M	
109-A9	Transaction Count	Same value as in request	M	
501-F1	Header Response Status	R = Rejected	M	
202-B2	Service Provider ID Qualifier	Same value as in request	M	
201-B1	Service Provider ID	Same value as in request	M	
401-D1	Date Of Service	Same value as in request	M	

Response Message Segment Questions	Check	Eligibility Verification – Rejected/Rejected
This Segment is situational.	X	Provide general information when used for transmission-level messaging.

Response Message Segment Segment Identification (111-AM) = "20"			Eligibility Verification – Rejected/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
504-F4	Message		RW	Required if text is needed for clarification or detail.

Response Status Segment Questions	Check	Eligibility Verification – Rejected/Rejected
This Segment is always sent.	X	

Response Status Segment Segment Identification (111-AM) = "21"			Eligibility Verification – Rejected/Rejected	
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
112-AN	Transaction Response Status	R = Rejected	M	
510-FA	Reject Count	Maximum count of 5 occurrences	R	
511-FB	Reject Code		R	
546-4F	Reject Field Occurrence Indicator		RW	Required if a repeating field is in error, to identify repeating field occurrence.
130-UF	Additional Message Information Count	Maximum count of 25 occurrences	RW	Required if Additional Message Information (526-FQ) is used.
132-UH	Additional Message Information Qualifier		RW	Required if Additional Message Information (526-FQ) is used.
526-FQ	Additional Message Information		RW	Required when additional text is needed for clarification or detail.
131-UG	Additional Message Information Continuity		RW	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it and the text of the following message is a continuation of the current.

End of Eligibility Verification Response (E1) Payer Sheet