Provider Manual 2020

Provider Manual

This Ventegra Provider Manual is designed to answer your questions regarding online claim submission for Ventegra plan participants and address other issues; this version supersedes all previous versions. The Provider Manual is an extension of and incorporated into the Participating Provider Agreement and is incorporated into the Participating Provider Agreement with Ventegra. The Provider must adhere to the provisions and terms set forth in the Participating Provider Agreement. Lack of adherence to any of the provisions and terms of the Participating Provider Agreement, which includes the Provider Manual, and all other applicable documents are viewed as a breach of the Participating Provider Agreement.
If you need additional information, please contact the applicable Provider Help Desk.

Ventegra PROVIDER HELP DESK **1**-877-867-0943.

Please refer to the member identification card and the online transaction response for the appropriate number to call.

VENTEGRA CUSTOMER CARE TEAM
877-867-0943 phone
818-230-0773 fax
Hours of Operation:
Monday through Friday 6:00 AM to 10:00PM Mountain Time
Saturday and Sunday 8:00AM to 8:00PM Mountain Time.

It is important to always refer to the Provider Web Portal at www.ventegra.com for the most up-to-date documents, Provider Manual, payer sheets, and other important communications. General questions can be referred to Ventegra, Inc., 450 North Brand Boulevard Suite 600, Glendale, CA 91203

Ventegra IDENTIFICATION CARDS/BANK IDENTIFICATION NUMBERS (RxBINs):

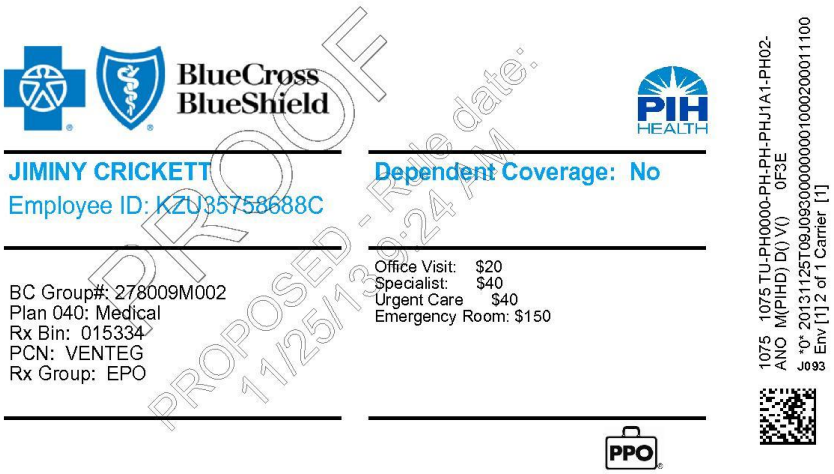
GENERAL INFORMATION

Payer Name: Ventegra	Date: 02/21/2013	
Plan Name/Group Name: Ventegra	BIN: 012528	PCN: VENTEG
Provider Relations Help Desk Info: 877-867-0943		

GENERAL INFORMATION

Payer Name: Ventegra	Date: 09/01/2016

Plan Name/Group Name: Ventegra	BIN: 018893	PCN: MEDB
Provider Relations Help Desk Info: 855-355-3015		



Member identification cards are generally printed using the standard format of the National Council for Prescription Drug Programs (NCPDP). Some plans have custom identification cards. Please ask the member for their ID card to ensure accurate submission.

Claim Submission

Provider Obligations
All claims must be submitted online within 30 days of the date the prescription was filled, unless longer period is permissible by client and or law. The following elements from the member identification card must be submitted for successful claims adjudication.

-Member identification number
-Person code (when printed on card)
-RxGRP (when printed on card)
-BIN/Processor Control Number

For additional required data elements, please refer to the applicable Payer Specifications .

Software
Ventegra requires that all claims must be submitted using NCPDP Telecommunication Standard Version D.0, later version, or other standard as dictated by applicable governing or industry setting organizations.

Reversals
Claims can be reversed up to 30 days after the submission date (or as specified by plan), but should be reversed within 14 days, or as soon as reasonably practical, or as specified by certain

governing requirement to assure prescriptions with inaccurate information or those not dispensed to members are credited in a timely fashion.

Formulary
Formularies vary by plan and can change regularly.

Compounds
All Ventegra plans require multi-ingredient compound claims submission as identified in the NCPDP D.0 standard. Please use the following guidelines when submitting compounds:

One of the ingredients must be a legend drug product,

Compound indicator field must indicate that the claim is a compounded prescription,

Appropriate fields in the compound segment (see payer sheet for additional information) must be completed,

Reimbursement is the lower of submitted cost, Usual and Customary price, or AWP. Other reimbursement pricing methods may be used. Submission of compounds are subject to increased audit and may incur additional costs should they be misrepresented,

Reimbursement for reasonable waste only includes associated volumes necessary in compounding the prescription which are not used within additional compound preparation.

Note: Reconstituted preparations, such as powdered antibiotics that are mixed with water prior to dispensing, reconstituted topical preparations, or compound kits are not considered compounded prescriptions.

Tax
Tax is calculated based on the applicable state or local law governing tax on prescription drugs. In order to be reimbursed for payment of tax, the Provider must enter the tax amount in the appropriate tax field.

Coordination of Benefits
Coordination of Benefits (COB) is handled on a plan-specific basis. The Provider is obligated to facilitate COB processing as a network participant. It is prudent for the Provider to verify with members to ensure they do not have alternative primary or secondary insurers. Please be sure to refer to the online transaction response to facilitate COB processing.

Processing, Pricing, Updates, Payments

Claims submitted by Provider for plans utilizing a Ventegra national network, plan, other network, or via electronic claims submission point-of-service adjudication system for retail prescription benefit management or prescription processing are reimbursed for prescription drugs at the lesser of the plan or network Average Wholesale Price (AWP) discount or other referenced based pricing; plus or minus a discount or Maximum Allowable Cost (MAC) or Acquisition Cost Index (ACI) (when applicable for prescription drug products); the Provider‘s submitted gross amount due, the Provider‘s Usual and Customary price (U&C) that would be given under the same circumstances if the member did not possess prescription benefit coverage; or submitted ingredient cost, and the applicable plan or network dispensing fee including taxes if applicable.

AWP, and brand or generic medication classification, is determined by Ventegra in all cases. Ventegra shall utilize client or plan parameters, Medi-Span or other national source, and internal processes as a reference but not as the sole determinant of price. WAC-referenced based pricing may be implemented should AWP become obsolete, if plan requires or market conditions warrant such pricing methodology. Other nationally recognized referenced based price sources may also be implemented as market conditions warrant or under the circumstances where AWP becomes obsolete.

All network reimbursement includes, but is not limited to, retail commercial, Medicare Part D (this includes Medicare Part D Long Term, Indian Health Services, Indian Tribal Organization, and Home Infusion), Medicaid, 340B, hospice care, prescription benefit program for injured employees / workers compensation programs, automobile accidents, consumer driven health plans, discount cards, over-the-counter products or other plan-defined custom networks, as applicable.

Providers are required to submit all claims via on-line adjudication where a member presents a prescription drug card with the aforementioned RxBINs; this includes, but is not limited to, all Provider or otherwise discount programs that are established as the Providers Usual and Customary price (even if the price is zero).

Upon successful adjudication of a claim, Provider has deemed to accept reimbursement terms conditions, and rates, and network participation with Ventegra. In the event of a conflict between the Provider Manual, Provider Agreement, Addendums, Fee Schedules, on-line adjudicated price or, any other pricing arrangement, the on-line adjudicated price shall govern, unless an error in overpayment occurs.

MAC means the maximum allowable cost for pharmaceutical products. The MAC(Maximum Allowable Cost) is developed by Ventegra and may be amended at any time at its sole discretion.

ACI means the acquisition cost index and is developed by Ventegra and may be amended at any time at its sole discretion.

Ventegra typically administers weekly billing cycles to ensure prompt pay in all states.

Provider agrees that they are prohibited from contacting Ventegra clients and its members (Ventegra client/plan) for disputed issues between Provider and client or Ventegra, including but not limited to processing issues, reimbursement or payment issues without written consent by an authorized Ventegra representative. Provider agrees that they are prohibited from directing the member or a member‘s claims to a plan other than the Ventegra plan presented by the member, and violation of such is considered a breach of contract, and subsequently subject to penalties or sanctions up to and including termination, as determined by Ventegra.

Claim System

The electronic claim processing system is generally available 24 hours per day, 7 days per week, with the exception of regularly scheduled downtime, which generally occurs at non-peak hours in order to minimize the impact to our network Providers. All claims must be submitted via

the online adjudication system. Variant transmission fees will be incurred by the Provider per on-line transaction. The transmission fees are assessed to support network Provider payment and reconciliation, help desk support, as well as but not limited to Provider network compliance, transactional, and billing education or other initiatives. However, excessive or disruptive process inquiries, including but not limited to non- contracted Provider status, duplicate payment and remittance requests, excessive member/Provider grievances, third party biller intervention, incomplete or inaccurate credentialing submissions, contract compliance and/or failure of the Provider to submit claims through the Ventegra designated adjudication on-line adjudication process are subject to higher transmission fees. Should a claim be submitted by a third party or other means separate from the Provider itself, the claim may be subject to non-payment. Ventegra reserves the right to make payment directly to Provider at its sole discretion.

Provider Audit

Ventegra, or its client, authorized agent, governmental agencies or their representatives,, hereafter referred to as Ventegra auditors, reserves the right to audit a Provider‘s compliance with the agreements in effect. Ventegra has the right to inspect all records of the Provider relating to this agreement. The Provider shall maintain adequate prescription and financial records relating to the provision of pharmaceutical services to our customers, including but not limited to: Provider books/databases, daily prescription logs, patient profiles, prescription hardcopies, prescriber information, signature/delivery logs, refill information, wholesaler-/ manufacturer/ distributor and all other purchase invoices and other such documentation necessary for all pharmaceutical services provided. Provider shall also maintain all policies and procedures related to maintenance of such records. Provider shall maintain and retain all records described herein for a minimum of (10) ten years or as required by state or federal law, regulations and guidance.

Ventegra auditors shall have the right to audit any Provider during normal business hours and upon reasonable notice (usually 14 days), unless required otherwise, for any aspect of performance under the Provider Agreement, to include the provisions set forth within this Provider Manual, by reviewing records and documents relating to such performance. Documents must be readily accessible. The Provider shall cooperate with Ventegra auditors, and promptly provide access to all information or documents deemed necessary by the Ventegra auditors. Ventegra at its sole expense may reproduce any record; however, no original copy may be removed from the Provider.

Ventegra may report audit findings to its clients, appropriate governmental entities, regulatory agencies, and professional review and audit organizations.

If a Ventegra auditor is denied access to the Provider on a scheduled and is not provided access to the required requested audit documents, 100% of the amount paid for that claim(s) become due immediately. Ventegra may offset this said amount against any future payments due to the Provider and impose certain fines or penalties. Any audit resulting in a financial recovery Ventegra may offset the said amount against future payments.

Types of Audits

Ventegra routinely monitors online claims data and conducts audits on a continuous basis. Ventegra auditors conduct industry standard desktop audits and on-site audits, scheduled during normal business hours with prior written notice, unless otherwise necessary and audits of

an investigational nature. In order to conduct these audits, Providers as directed may be contacted by telephone, mail, fax, and or email and are required to provide such records by the due date in a manner mutually agreeable by the parties, while at all times ensuring safe transmission of sensitive documentation.

Telephone Audits

Ventegra monitors claims data for potential billing errors and reasonable claim submissions on a daily basis. If a potential discrepancy is found, a Ventegra auditor will contact the Provider as directed via telephone to inquire about, validate, and help resolve the discrepancy. Unless supporting documentation is required, most of these discrepancies can be validated over the telephone and resolved through claim reversal and resubmission by the Provider.

Desktop Audits and Investigational Audits

Ventegra conducts desktop audits and investigational audits to verify the accuracy and validity of claim submissions. Providers, as directed, are typically contacted via telephone, fax or mail and asked to provide photocopies of specific documents and records related to claims paid to the Provider by Ventegra during a specified period. Requested documentation may include, but not be limited to, original prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications. Ventegra will identify any discrepancies found in the documentation and will advise the Provider as such via post audit reports.

Onsite Audits

Ventegra conducts onsite Provider audits that are scheduled during normal business hours with prior written notice unless otherwise necessary. Onsite Auditors require a clutter free work area which is located away from the busiest area of the dispensing department with easy access to the required documents outlined in the audit notice; Ventegra auditors attempt to minimize any disruption of the business processes while on-site. Please note; it is also helpful to have assistant dedicated Provider staff member present to answer general questions, retrieve information required and facilitate an effective on-site audit. The Provider shall receive a post audit report, which allows for a 30 calendar day period, unless another time is dictated by state or federal guidelines or law, to contest any findings identified. At the completion of the audit the Provider shall also receive a final audit report with the claims identified as discrepant and due for recovery. All documentation must be received no later than 30 calendar days from the date of the discrepancy report. Beyond that date, the audit shall be considered final.

Documentation

Original Prescriptions

All prescription documentation, regardless of the way it has been created, generated or transmitted shall contain the following:

Full name of the member for whom the prescription was written, and the address of the member along with a date of birth,

Full name and address, telephone number and any other required identifiers of the prescriber,

Name, strength and quantity of the medication prescribed,

Specific dosing directions, if a prescription contains ambiguous directions the Provider must clarify these directions and notate the conversation to clarify,

Substitution instructions where applicable, or substitution requested by member clearly notated,

Refill instructions, Miscellaneous or other informational notations as required by applicable laws or regulations, and complete documentation of items, quantities to be dispensed, and directions for use for diabetic supplies and insulin.

Prescription records must be updated at a minimum yearly, or such shorter period required by applicable law; if applicable law does not specify a time period, Ventegra requires that prescription hard copies be updated yearly.
Ventegra recommends that Providers document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the auditor or help resolve a discrepancy.

Compound Medication
Compounded medications (see additional section Compounds within the Claim Submission section of this Provider Manual) require the following additional documentation:
A detailed compound worksheet documenting the products, NDC‘s of the products, quantity used, costs associated with each product and compounding procedures, and

A valid prescription which clearly details the intent of the prescriber for the medication being compounded.

Signature Log – Hard Copy or Electronic
Provider must utilize a signature/delivery log that contains all the information required by Ventegra. This should include; fill date, date of pickup, the prescription number, third party name, patient or patient representative signature or electronic capture of information to prove receipt of medication, and the authorization to release information to a third party program. Provider must obtain a legible written signature or electronic capture that corresponds to a matched printed name or another authorized person to confirm receipt of the prescription product Capture of non-signature data elements to document receipt of the medication (e.g. electronic delivery notice or point of sale information) must be only upon express permission of Ventegra. If any state or federal laws require additional verification of the person picking up the medication, please include this notation on the signature log documents. Proper verification of the person picking up the prescription is essential to ensure the deterrence of potential fraud and abuse.

If delivered to a home or business address, Provider must obtain the signature at the time of delivery.

If patient is sent monthly billing statements, Provider may insert a form listing the dates of fill and prescription numbers; the Eligible Person or authorized representative should be instructed to sign and return the form with his/her payment.

Provider utilizing mail services must include information to document tracking of shipment, confirmation of delivery, or other proof of delivery.

These prescription signature logs must be in date order where appropriate and readily accessible for a minimum of three years or longer as required by law.

Wholesaler, Manufacturer and Distributor Invoices
Wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents must be accessible and also maintained for a minimum of three years or as required by law or regulation to substantiate that the drugs dispensed were purchased from an authorized source. Provider must be able to document the source is authorized to include state or federal licensure, oversight by regulatory agencies to include the Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA), and ability to obtain pedigree information for medications. The Provider must promptly comply with any requests to produce such documentation. If the Provider fails to promptly provide such requested documents, Ventegra may offset 100% of the amount for any of the paid claims in question and impose additional fines or penalties.

Submissions and Documentation Expectations
Please use the following information to help avoid problems and be prepared for an audit.

Days' Supply and Quantity Submission

Providers are responsible for entering the correct days supply of medication for all submissions. Audits routinely include discrepancies for days supply errors. Therapy should be included in determination of days supply. Examples of appropriate days supply submission include:
The days supply for 28 doses of a medication, taken 28 per month, is 30 days, and

The days supply for 4 patches, 1 patch applied once weekly, is 28 days.

Provider must clarify ambiguous dosage instructions regarding utilization prior to dispensing. If a prescription contains ambiguous directions (e.g. no directions, —Use as Directed, ‖ or —prn‖), Provider must obtain more detailed directions so the days supply can accurately be calculated. The directions may be obtained by direct communications with either the patient or Prescriber. Documentation of the directions on the original prescription is required. The days supply should accurately reflect the documented directions and quantity dispensed.

Other required days supply and quantity submission requirements are as follows:

-The quantity dispensed must be entered exactly as it is on the prescription or as documented if less than prescribed,

-Provider must enter the exact metric decimal quantity dispensed (no rounding),

-Provider should review claims submission to ascertain that the quantity is accurate on all claims based on the specificity of the product and Prescriber instructions,
If the Prescriber indicates ambiguous directions, the Provider must determine the dosing schedule in order to submit the claim correctly,

-If the quantity to be dispensed is uncertain, the Provider must contact the Prescriber to determine the appropriate amount to dispense and document said amount appropriately on the original prescription,

-Any subsequent changes in the original dispensing limitations (i.e. increase in quantity) that are approved by the Prescriber must be documented on the original prescription or in a readily retrievable electronic format, acceptable by the State Board of Pharmacy in which Provider is located, A 30-day supply is no longer standard; some programs permit extended days supplies.

-Always transmit the accurate days supply and allow the on-line system to communicate the allowable days supply,

-Claims submitted to Ventegra in accordance with a client program to allow limited dispensing of a non-covered item (e.g. three (3) day supply approved for a drug requiring Prior Authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable days supply.

Insulin and Diabetic Supplies

Provider may only submit the NDC associated with the actual insulin or diabetic supply filled and dispensed. Diabetic insulin and supply must be calculated to accurately submit the days supply Directions notated —as needed or —as directed require a documented interaction with the prescriber or patient on the prescription.
If the Prescriber indicates —as directed or —as directed as per sliding scale, the Provider must obtain the dosage range, note it on the prescription hard copy, and calculate the days supply by using the maximum daily dosage. The directions may be obtained by direct communications with either the patient or Prescriber.

Inhalers and Inhalation Products

When submitting a claim, enter the quantity to be dispensed exactly as written by the Prescriber on the prescription form. Dispensing limitations vary widely among plans. Depending on the patient‘s medical condition, it may be necessary to dispense more than one inhaler. If plan design allows and the Prescriber writes accordingly, the patient may obtain more than one inhaler per prescription.

Product Selection (Dispense as Written) Codes

Ventegra supports the NCPDP standard Product Selection Codes (PSC‘s). Accurate reimbursement is tied to proper PSC submission; the Provider must always specify the correct PSC when submitting a claim. Please be advised that incorrect PSC codes are the most common cause of Provider chargebacks and may lead to removal from the network.
Product Selection Codes (PSC):

PSC 0 - Dispense as Written: Substitution Allowed, or no product selection indicated
Use the PSC 0 code when dispensing a generic drug; that is, when no party (i.e., neither prescriber, nor pharmacist, nor member) requests the branded version of a multi-source product.

PSC 1 – Substitution not allowed by prescriber
Use when the Prescriber specifies the branded version of a drug on the hard copy prescription or in the orally communicated instructions.

Must be evidenced on the prescription hard copy (original and updates). This documentation must occur prior to services being rendered; that is, before the medication is dispensed.
No PSC 1 code defaults should be set; this leads to removal form the network.

PSC 2 - Substitution allowed - patient requesting product dispensed

A PSC 2 code should be transmitted when the member requests that the prescriber be contacted to obtain approval for a brand drug when the prescriber did not initially mandate dispense as written.
Must be evidenced on the prescription hard copy (original and updates). This documentation must occur prior to services being rendered; that is, before the medication is dispensed.

PSC 3 - Substitution allowed - pharmacist selected product dispensed

PSC 4 - Substitution allowed - generic drug not in stock

PSC 5 - Substitution allowed - brand drug dispensed as a generic
Use when dispensing a brand as a generic.

PSC 6 – Override
Not in use

PSC 7 - Substitution not allowed; Brand mandated by law

PSC 8 - Substitution allowed - generic drug not available in marketplace
Proof from wholesaler is required proving the generic was not available on fill date and will be requested upon audit.

PSC 9 – Other
Not in use

Some members have a choice between brand and generic drugs. However, in some programs, the member pays the difference between the cost of the brand and the available generic drug.

Prescriber Identification
Identification of the prescriber requires a National Provider Identifier (NPI). For all claims, including controlled substance prescriptions, the Provider must use the Prescriber‘s NPI If the Prescriber does not have an NPI or Provider cannot obtain the Prescriber‘s NPI after making reasonable efforts to do so, an alternative identifier may be submitted as permitted by State and Federal guidelines and regulations.. Provider must maintain the DEA number on the original hard copy for all controlled substance prescriptions in accordance with State and Federal Laws. Provider is responsible to confirm the Prescribers ability to prescribe a controlled substance, e.g. confirmation that they are allowed to prescribe CII medication when claimed medication is a CII.

Ophthalmic Products
Eye drops should be calculated using 15 drops per mL, unless a more specific drop per mL or uses/package exists. Prescriptions with defined length of therapy may use that period for days

supply when smallest package size for therapy is used (e.g. 5ml ophthalmic with acute therapy of 5 days).

Prescription Hard Copies
The hard copy (original and any updates) of the prescription, including telephone prescriptions, must contain data elements required by state pharmacy laws in which Provider is located and all of the prescriber instructions — including Product Selection Code instructions — that support the Provider‘s claim transmission.

Prescriptions in which the dosage/quantity is changed require either written documentation on the prescription or a new hard copy prescription to be issued. In cases of the prescriber writing —As Directedǁ, documentation as to the exact directions or, at a minimum, the maximum (—up toǁ) dose of medication taken per day must be documented on the hard copy or electronically and be viewable upon request. If undocumented at the time of the audit, the entire claim is marked as discrepant until proper documentation is provided. Only prescriptions generated by the prescriber are accepted as post audit documentation for as directed prescriptions. If less or more medication (if permitted) is given than ordered by the prescriber, the reason for this must be documented. Any increase in the amount of medication over the original prescribing order must be documented for prescriber authorization.

Signature Log

Provider shall require the signature of the member or the member‘s representative on a permanent record before dispensing any prescription. At each Provider location, Provider shall maintain a hard copy or (pre-approved by Ventegra) electronic signature log which contains the following: the prescription number; the date the medication is received by the member; and the signature of each member who receives a medication or the signature of his/her designee. A log in date order must be maintained for all claims submitted on-line to Ventegra. Signature logs must be maintained for ten years or longer—corresponding to the state and/or federal regulations and law, which Provider is located for retaining prescription hard copies. The logs must be available for inspection and audit by a Ventegra auditor.

Dispensing Limitations

Enter the quantity to be dispensed exactly as written on the prescription form. A 30-day supply is no longer standard; some programs permit extended days supplies. Always transmit the accurate days supply and allow the on-line system to communicate the allowable days supply. Note subsequent changes or refill authorizations approved by the prescriber on the hard copy, or in a readily retrievable electronic format, acceptable by the State Board of Pharmacy in which Provider is located.

U&C

Usual and Customary (U&C) charge means the usual and customary price charged by the Provider to the general public at the time of dispensing, including any advertised or sale prices, discounts, coupons or other deductions.

Product Selection Codes (PSC)

When an auditor cites a prescription for a missing or incorrect PSC code, follow-up documentation is not permitted. A transmitted PSC 1 code must be supported on the prescription hard copy (original and update). No PSC 1 code defaults should be set; this leads to removal form the network. A PSC 2 code should be transmitted when the member requests that the prescriber be contacted to obtain approval for a brand drug when the prescriber did not initially mandate dispense as written. Avoid use of PSC 7 for NTI drugs, please use the correct codes 0, 1, or 2 and communicate with the prescriber.

Long Term Care (LTC)

Ventegra reserves the right to audit an LTC Provider‘s books, records, prescription files and signature logs for the purpose of verifying claims submission information. LTC Providers are required to have signed prescriber‘s order available for audit. These orders may be in the form of a standard prescription or copies of signed prescriber‘s orders from a medical chart. Record retention is important, and time to retrieve these documents is considered in complying with audit requirements. LTC Providers are not required to have a signature from the member as proof of receipt. However, LTC Providers must have delivery logs, manifests or other Ventegra approved proof of delivery of medications to facilities readily available during an audit. Abuse of the Short Cycle Dispensing regulations as defined by CMS to be implemented on 1/1/2013 will be subject to audit and recover of abuse and attempt to achieve multiple dispensing fees based on days supply manipulation. Ventegra may audit for an attempt to gain more than 2 dispensing fees in a one month period.

Miscellaneous

Claims are adjudicated based on data provided to Ventegra. If a claim is adjudicated based on incorrectly submitted data, an adjustment may be necessary. Provider must charge the member the patient pay amount indicated in the on-line response. Provider should follow all audit guidelines as notated on the communications to the Provider via telephone, letter or electronic requests. Ventegra may deny payment for unsupported claims or missing signatures. Ventegra has the right to assess reasonable fines, penalties and fees to cover unexpected costs. These actions may include the imposition of fines or penalties due to repeated audits, termination from the network, corrective action plans. Please refer to the audit communications as provided by Ventegra auditors for discrepancies identified and the actions a Provider can take to remedy these discrepancies.

Fraud, Waste and Abuse (FWA)

Ventegra does not knowingly allow fraudulent activity of any kind by any of its contracted Providers, associates, members, vendors, contractors and/or other business entities, and investigates and reports any such known activity to the appropriate regulatory, federal and state agencies for further action and investigation. Ventegra contracts with clients, including those which are Medicare or Medicaid entities. These clients are required by the Centers for Medicare & Medicaid Services (CMS) to have a comprehensive plan to detect, correct and prevent fraud, waste and abuse. Providers are required to maintain proper policies and procedures related to training on Compliance, Fraud, Waste and Abuse and must have a policy and procedure for checking the Office of the Inspector General (OIG) List of Excluded Individuals (LEIE) and Government Services Administration (GSA) Excluded Parties Lists System (EPLS) to confirm no employee, volunteer, consultant, governing body member, or contracted individual or entity is excluded from participation in federal programs. LEIE and EPLS verifications must be conducted at least monthly and upon initial hire or contracting. Providers are required to maintain training logs of all required trainings, type and method, vendor and date and time and signoffs from the staff on its completion when required by Ventegra or clients. These logs must be made available within 72 hours to Ventegra in case of an audit or CMS request. If you find

that an individual or entity responsible for the provision of pharmacy services is on the LEIE or EPLS as excluded you have a duty to report this issue and all the claims associated with this individual or entity to Ventegra at the Provider Relations address contained herein or to the Ventegra FWA hotline at the toll-free number at 888-625-5685, available any time, 24 hours a day, seven days a week. The appropriate entry of the Prescriber and patient information is paramount in being able to identify true occurrences of fraudulent and abusive practices as well as reduction in waste associated with payment of claims for excluded Prescribers. Please see the Prescriber Identification section of this Provider Manual for additional details. Provider also agrees that they will follow all federal or state requirements to include Medicaid rules in instances of state Medicaid managed care programs, including accurate submissions and temporary supply rules which are mandated by many of these programs. In addition, the Provider will facilitate when professionally capable or provide a valid reason for their inability to participate in a state Medicaid plans Lock –In program for its membership. The Provider can always report any suspected fraud, waste or abuse by calling the Ventegra Ethics and Compliance Hotline, toll-free number at 1-877-217-4679, available 24 hours a day, and seven days a week.

FWA Program

An entity involved in providing services for Medicare Part D members is responsible for implementing a program to control fraud, waste and abuse and to facilitate compliance in the delivery of prescription drugs through the Medicare benefit. Examples of Provider fraud may include the following:

• Filling less than the prescribed quantity of a drug,

• Billing for brand-name drugs when generic drugs are dispensed,

• Billing multiple payers for the same prescriptions,

• Dispensing expired or adulterated prescription drugs,

• Forging or altering prescriptions,

• Refilling prescriptions erroneously,

• Billing for non-existent prescriptions,

• Prescription drug shorting-without notifying the member,
• Illegal remuneration schemes,
• TrOOP manipulation,
• Manipulation of quantity limits.

The Provider will notify Ventegra on the FWA hotline at 1- 888-625-5685 if the Provider has reason to believe potentially fraudulent prescription or inappropriate claims activity is occurring. Examples of member or prescriber fraud may include the following:
a member presenting a prescription not written by the prescriber identified,

a member presenting a forged or altered prescription, calling in their own prescriptions, over-utilizing prescriptions, selling their prescriptions or membership information,

Medications inconsistent with the practice or specialty of a Prescriber,

Illegal remuneration schemes,

Prescriptions not medically necessary and,

Cash or other benefits to switch drugs to prescribe certain medications.

Compliance and Fraud, Waste and Abuse (FWA) training is an important component of Provider operations and is required to be completed annually and upon initial hire for all local, state and federally funded pharmacy benefit programs. For example, CMS requires that FWA be completed by anyone who works with or, provides services to or supports the Medicare Part D drug plan benefit. To assist Providers with this training Ventegra has posted various materials on our website www.informedRx.com. As noted in that training material, the Provider must complete the training and keep a record of completion of the Ventegra General Medicare / Medicaid Compliance and Fraud, Waste and Abuse Training for Participating Providers or any other generally acceptable training module. Should the Provider not have access to the internet, please feel free to contact Provider Relations to obtain additional information on how to maintain compliance. Annually and upon reasonable request, Providers are required to attest to the training mentioned above and provide specific proof down to the employee and or contractor level that such training was completed as per the provisions notated above. Non-compliance with this provision may result in remedies to include corrective actions or termination of the Providers from the Ventegra network.

Credentialing and Quality Management
Provider must comply with the credentialing and quality management initiatives required by Ventegra. Provider agrees to provide Ventegra with documentation and other information that may be needed in connection with such initiatives.
Ventegra has the right to reasonably determine, at its sole discretion, whether or not Provider meets and maintains the appropriate credentialing and quality management standards to serve as a Provider for Ventegra and its clients.

Standards of Operation
Provider must meet all standards of operation as described in Federal, State and local law as related to the provision of pharmacy services. Shipping pharmacy services to patients by mail or other remote delivery carrier as a routine business practice is unapproved without the express written permission of Ventegra.

Licensure

Provider must at all times maintain in good standing with all Federal, State and local licenses and/or permits as required by applicable state and or federal law, regulations, and guidelines
Provider must furnish copies of said licenses and/or permits upon enrolling as a Provider with Ventegra and as requested by Ventegra. Failure to maintain the appropriate licenses and/or permits will result in immediate termination as a Provider.
Provider must notify Ventegra in writing at the Provider Contracting address below, if:
Provider‘s license or permit is, or is in jeopardy of being, suspended or revoked;
Provider receives notice of any proceedings that may lead to disciplinary action;
Any disciplinary action is taken against Provider or any of its personnel, including but not limited to, action taken by a Board of Pharmacy, OIG, GSA, law enforcement or other regulatory body;
There is a subpoena of records related to pharmacy services or Provider‘s business conduct;
There is a seizure by law enforcement of Provider‘s prescription records, computer systems, financial records, accounts or real property;
There is an investigation by law enforcement or regulatory body related to pharmacy services.

Required notification to Ventegra must be provided within 7 days of the occurrence and include information of the agency conducting the investigation or governing the disciplinary action, if applicable. Failure to timely and properly notify Ventegra may result in immediate termination of the Provider Agreement or suspension as a participating Provider. Ventegra may in its sole and absolute discretion immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding or claims adjudication suspension) of Provider if Ventegra has reason to believe that Provider has engaged in, or is engaging in, any behavior which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; or (3) otherwise reflects negatively upon the Provider's ability to fulfill the requirements of the Provider Agreement.

Suspension and Termination
Providers who are not eligible to participate in Medicare, Medicaid, and other Federal health care programs are not eligible to participate in any of the Ventegra networks. If a provider is found to be excluded from participation in Federal health care programs, the Provider will be immediately terminated from participation in all Ventegra networks.
Provider shall not allow any employers or contractors excluded from participation in Medicare, Medicaid, and other Federal health care programs to provide services that involve furnishing, ordering or prescribing an item or service that will be paid by Medicare, Medicaid, or other Federal health care programs.
Ventegra suspension may include cancellation of checks, payment suspension of future cycle checks, or restriction of claims submission. Ventegra's ultimate remedies under this section include immediate termination of the Provider Agreement.

Insurance
Provider must at all times hold policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that the Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000.00 per person and $3,000,000.00 in aggregate, unless otherwise agreed to by Ventegra, or such greater amount required by Law.

The Provider must furnish copies of said policies upon enrolling as a Provider with Ventegra and as requested by Ventegra thereafter. Failure to maintain the minimum coverage may result in immediate termination as a Provider.
The Provider must notify Ventegra immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to immediately notify Ventegra in writing of any such termination of insurance coverage may result in immediate termination as a Provider.
The requirements in this section apply to the extent permissible under applicable federal and state regulations, guidance and laws.

Quality Management

The Provider must participate in quality management initiatives or other client sponsored programs, as requested by Ventegra and/or client The Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Ventegra.

Miscellaneous

ACI or MAC pricing appeals should always be directed to Ventegra; appeal requests must be submitted on our current available by contacting our Pharmacy Network Department network@ventegra.com. All fields on the form are required; incomplete forms may not be acknowledged. Your most recent invoice for the NDC submitted on the claim must accompany the appeal form. Please submit using the information provided on the form within 45 days of the claim fill date. Responses will only come via fax or email to the original requesting Provider.

Ventegra updates its files through the providers submission of information.

Payer Sheet
GENERAL INFORMATION

Payer Name: Ventegra	Date: 02/21/2013	
Plan Name/Group Name: Ventegra	BIN: 012528	PCN: VENTEG
Processor: New Tech Computer Systems		
Effective as of: 02/21/2013	NCPDP Telecommunication Standard Version/Release #: D.Ø	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 04/2012	
Contact/Information Source: Trent Jackson		
Certification Testing Window: N/A		
Certification Contact Information: Certification not required		
Provider Relations Help Desk Info: 877-867-0943		
Other versions supported: N/A		

TRANSACTIONS SUPPORTED

Payer: *Please list each transaction supported with the segments, fields, and pertinent information on each transaction.*

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal

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.	

Payer Usage Column	Value	Explanation	Payer Situation Column
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	
QUALIFIED REQUIREMENT	**RW**	“Required when”. The situations designated have qualifications for usage.	
SITUATIONAL	**S**	The Field has been designated situational.	
OPTIONAL	**O**	The Field has been designated as optional and is not required.	

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.

CLAIM BILLINGTRANSACTION

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

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	012528	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	VENTEG	M	
1Ø9-A9	TRANSACTION COUNT	01 to 04	M	

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

	Insurance Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	04	M	
3Ø2-C2	CARDHOLDER ID		M	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		S	
301-C1	GROUP ID		M	
303-C3	PERSON CODE		R	
306-C6	PATIENT RELATIONSHIP CODE		O	

	Patient Segment			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	01	M	
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	
323-CN	PATIENT CITY ADDRESS		O	
324-CO	PATIENT STATE/PROVINCE ADDRESS		O	
325-CP	PATIENT ZIP/POSTAL ZONE		O	
326-CQ	PATIENT PHONE NUMBER		O	

	Claim Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	07	M	

	Patient Segment			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW) CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		R	
419-DJ	PRESCRIPTION ORIGIN CODE		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT		R	
42Ø-DK	SUBMISSION CLARIFICATION CODE		R	
3Ø8-C8	OTHER COVERAGE CODE		S	
461-EU	PRIOR AUTHORIZATION TYPE CODE		S	

	Patient Segment			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
462-EV	PRIOR AUTHORIZATION NUMBER		S	
996-G1	COMPOUND TYPE		O	

	Pricing Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	11	M	
4Ø9-D9	INGREDIENT COST		R	
412-DC	DISPENSING FEE		R	
438-E3	INCENTIVE AMOUNT		S	
481-HA	FLAT SALES TAX AMOUNT		RW	If sales tax is required
482-GE	PERCENTAGE SALES TAX AMOUNT		RW	If sales tax is required
483-HE	PERCENTAGE SALES TAX RATE		RW	If sales tax is required
484-JE	PERCENTAGE SALES TAX BASIS		RW	If sales tax is required
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		O	

	Prescriber Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	03	M	
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider ID	R	
411-DB	PRESCRIBER ID		R	
427-DR	PRESCRIBER LAST NAME		R	
364-2J	PRESCRIBER FIRST NAME		O	

	Coordination of Benefits Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	05	M	
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		M	
34Ø-7C	OTHER PAYER ID		M	
443-E8	OTHER PAYER DATE		M	
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	M	
472-6E	OTHER PAYER REJECT CODE		M	

	Coordination of Benefits Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	M	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		M	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		M	
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	O	
393-MV	BENEFIT STAGE QUALIFIER		O	
394-MW	BENEFIT STAGE AMOUNT		O	

	DUR/PPS Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	08	M	
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	O	
439-E4	REASON FOR SERVICE CODE		O	
44Ø-E5	PROFESSIONAL SERVICE CODE		O	
441-E6	RESULT OF SERVICE CODE		O	
474-8E	DUR/PPS LEVEL OF EFFORT		O	
475-J9	DUR CO-AGENT ID QUALIFIER		O	

	DUR/PPS Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
476-H6	DUR CO-AGENT ID		O	

	Compound Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	10	M	
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	03 = National Drug Code	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		O	

CLAIM REVERSAL TRANSACTION

	Transaction Header Segment			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	012528	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	VENTEG	M	
1Ø9-A9	TRANSACTION COUNT	01	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National der ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

	Insurance Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	04	M	
301-C1	GROUP ID		R	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	07	M	
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
4Ø3-D3	FILL NUMBER		R	

GENERAL INFORMATION

Payer Name: Ventegra	Date: 09/01/2016	
Plan Name/Group Name: Ventegra	BIN: 018993	PCN: MEDB
Processor: New Tech Computer Systems		
Effective as of: 09/1/2016	NCPDP Telecommunication Standard Version/Release #: D.Ø	
NCPDP Data Dictionary Version Date: 07/2007	NCPDP External Code List Version Date: 04/2012	
Contact/Information Source: Trent Jackson		
Certification Testing Window: N/A		
Certification Contact Information: Certification not required		
Provider Relations Help Desk Info: 877-867-0943		
Other versions supported: N/A		

TRANSACTIONS SUPPORTED

Payer: *Please list each transaction supported with the segments, fields, and pertinent information on each transaction.*

Transaction Code	Transaction Name
B1	Claim Billing
B2	Claim Reversal

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the	

Payer Usage Column	Value	Explanation	Payer Situation Column
		Segment in the designated Transaction.	
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage.	
SITUATIONAL	**S**	The Field has been designated situational.	
OPTIONAL	**O**	The Field has been designated as optional and is not required.	

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.

CLAIM BILLINGTRANSACTION

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

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	012528	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	VENTEG	M	
1Ø9-A9	TRANSACTION COUNT	01 to 04	M	

	Transaction Header Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

	Insurance Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	04	M	
3Ø2-C2	CARDHOLDER ID		M	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE		S	
301-C1	GROUP ID		M	
303-C3	PERSON CODE		R	
306-C6	PATIENT RELATIONSHIP CODE		O	

	Patient Segment			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	01	M	
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	
323-CN	PATIENT CITY ADDRESS		O	
324-CO	PATIENT STATE/PROVINCE ADDRESS		O	
325-CP	PATIENT ZIP/POSTAL ZONE		O	
326-CQ	PATIENT PHONE NUMBER		O	

	Claim Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	07	M	

	Patient Segment			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW) CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		R	
419-DJ	PRESCRIPTION ORIGIN CODE		R	
354-NX	SUBMISSION CLARIFICATION CODE COUNT		R	
42Ø-DK	SUBMISSION CLARIFICATION CODE		R	
3Ø8-C8	OTHER COVERAGE CODE		S	
461-EU	PRIOR AUTHORIZATION TYPE CODE		S	

	Patient Segment			**Claim Billing**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
462-EV	PRIOR AUTHORIZATION NUMBER		S	
996-G1	COMPOUND TYPE		O	

	Pricing Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	11	M	
4Ø9-D9	INGREDIENT COST		R	
412-DC	DISPENSING FEE		R	
438-E3	INCENTIVE AMOUNT		S	
481-HA	FLAT SALES TAX AMOUNT		RW	If sales tax is required
482-GE	PERCENTAGE SALES TAX AMOUNT		RW	If sales tax is required
483-HE	PERCENTAGE SALES TAX RATE		RW	If sales tax is required
484-JE	PERCENTAGE SALES TAX BASIS		RW	If sales tax is required
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		O	

	Prescriber Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	03	M	
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider ID	R	
411-DB	PRESCRIBER ID		R	
427-DR	PRESCRIBER LAST NAME		R	
364-2J	PRESCRIBER FIRST NAME		O	

	Coordination of Benefits Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	05	M	
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		M	
34Ø-7C	OTHER PAYER ID		M	
443-E8	OTHER PAYER DATE		M	
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	M	
472-6E	OTHER PAYER REJECT CODE		M	

	Coordination of Benefits Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	M	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		M	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		M	
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	O	
393-MV	BENEFIT STAGE QUALIFIER		O	
394-MW	BENEFIT STAGE AMOUNT		O	

	DUR/PPS Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	08	M	
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	O	
439-E4	REASON FOR SERVICE CODE		O	
44Ø-E5	PROFESSIONAL SERVICE CODE		O	
441-E6	RESULT OF SERVICE CODE		O	
474-8E	DUR/PPS LEVEL OF EFFORT		O	
475-J9	DUR CO-AGENT ID QUALIFIER		O	

	DUR/PPS Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
476-H6	DUR CO-AGENT ID		O	

	Compound Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	10	M	
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	03 = National Drug Code	M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION		O	

CLAIM REVERSAL TRANSACTION

	Transaction Header Segment			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	012528	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	VENTEG	M	
1Ø9-A9	TRANSACTION COUNT	01	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 = National der ID	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	

	Insurance Segment			**Claim Billing**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	04	M	
301-C1	GROUP ID		R	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
111-AM	SEGMENT IDENTIFICATION	07	M	
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		M	
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
4Ø3-D3	FILL NUMBER		R	