

Centers for Medicare & Medicaid Services (CMS)

Common Electronic Data Interchange (CEDI)

Companion Guide

Communications/Connectivity Information (CCI)

Instructions Related to Transactions Based on NCPDP Telecommunication Standard Version D.0 NCPDP Batch Standard Version 1.2

Companion Guide Version Number: 1.11
October 2026

Disclosure Statement

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare claims is restricted under the provisions of the Privacy Act of 1974 and Health Insurance Portability and Accountability Act of 1996. This Companion Guide is to be used for conducting Medicare business only.

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated National Council for Prescription Drug Program (NCPDP) version D.0. Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by NCPDP's copyrights and Fair Use statement.

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1 Communications/Connectivity Introduction

1.1 Scope

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification that directs the federal government to adopt national standards for automated transfer of certain health care data between health care payers, plans, providers, and clearinghouses. The initial final rule was published August 17, 2000, became effective October 16, 2000 and was fully implemented October 16, 2003.

The Health Insurance Portability and Accountability Act commissioned the National Council for Prescription Drug Programs (NCPDP) format for use by retail pharmacies that transmit Medicare Durable Medical Equipment (DME) retail drug claims electronically. The Modifications Final Rule has mandated a change to the HIPAA standard version of the NCPDP format. Retail pharmacies using the NCPDP format to submit electronic Medicare DME claims must transition to Telecommunication Standard Version D.0 and Batch Standard Version 1.2 by January 1, 2012.

In addition, on October 13, 2010 an announcement of maintenance changes was published in the Federal Register notifying of correction information referenced in the NCPDP Version D Editorial Document. The corrections are included in the Telecommunication D.0 guide dated August 2010.

The NCPDP standard is accepted for DME MAC retail pharmacy drug claims only and cannot be used to submit DME MAC claims for supplies and services. DME MAC claims for supplies and services must can only be billed using version 5010 of the ASC X12 837 and must be submitted in a separate transmission from the NCPDP retail drug claims.

The NCPDP Batch Standard Implementation Guide (IG) version 1.2, Telecommunication Standard Implementation Guide (IG) version D.0, External Code List (ECL) and Data Dictionary are available for NCPDP members to download from the NCPDP website (https://www.ncpdp.org). The NCPDP Version D Editorial Document is freely available at NCPDP website – HIPAA Information (https://www.ncpdp.org/Resources/HIPAA-Information).

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with Medicare. In addition, this Companion Guide has been written to assist you in designing and implementing transaction standards to meet Medicare's processing standards. This information is organized in the sections listed below:

- *Getting Started:* This section includes information related to system operating hours, provider data services, and audit procedures. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.

- *Implementation and Transaction Testing:* This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.
- *Connectivity with the Payer / Communications:* This section includes information on Medicare's transmission procedures as well as communication and security protocols.
- *Contact Information:* This section includes EDI customer service, EDI technical assistance, provider services and applicable websites.
- *Control Segments/Envelopes:* Details of the Medicare usage of the NCPDP D.0 records.
- *Acknowledgments and Reports:* This section contains information on the TRN Acknowledgement and the NCPDP Transmission Response Report showing accepted and rejected files and/or claims for all transaction acknowledgments sent by Medicare and report inventory.
- *CCI Additional Information:* This section contains information related to implementation checklist, transmission examples, Trading Partner Agreements and other resources.
- *Medicare NCPDP Version D.0 Payer Sheet:* This section contains Medicare and CEDI information for the submission of the NCPDP D.0 claim and receipt of the NCPDP Transmission Response Reports.

1.3 References and Additional Information

The following websites provide additional documentation necessary for exchanging NCPDP claim transactions with CEDI.

Table 1. Additional Documentation for exchanging NCPDP with CEDI

Resource	Location
NCPDP information including purchase of the NCPDP guides	https://www.ncpdp.org
CMS website page for X12 version 5010 and NCPDP version D.0	https://www.cms.gov/MFFS5010D0
CEDI website	https://cedi.wellpointfederal.com

2 Getting Started

2.1 Working Together

Wellpoint Federal must conduct an analysis of the capability of each supplier, billing agent or clearinghouse who contacts CEDI to begin the exchange of DME electronic transactions including claims, electronic remittance advice, and claim status inquiry/response. CEDI will assign an EDI submitter identification number (Trading Partner ID) to those approved to use CEDI.

Suppliers who will be using a third party (billing agent or clearinghouse) to exchange electronic transactions with CEDI are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and requirements that apply to the supplier in regard to viewing or use of Medicare beneficiary data. The supplier must also not share their personal EDI access number and password with any billing agent, clearinghouse, network service vendor, and/or to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim; and that no other non-staff individuals or entities may be permitted to use a supplier's EDI number and password to access Medicare systems.

Third parties must obtain and use their own unique EDI access number and password from those Medicare contractors to whom they will send or from whom they will receive EDI transactions. A supplier must obtain an NPI and furnish that NPI to their Medicare contractor prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. A supplier's EDI number and password serve as a supplier's electronic signature and the supplier would be liable if any entity with which the supplier improperly shared the ID and password performed an illegal action while using that ID and password. A supplier's or Trading Partner's EDI access number and password are not part of the capital property of the supplier's or Trading Partner's operation. A new owner must obtain their own EDI access number and password. EDI transactions are to be presented as the normal mode of business for Medicare claims, claim status, and remittance. Where the provider does not have the related capability CEDI will inform the providers of available options to begin use of EDI, e.g., list of vendors, clearinghouses and billing services and availability of Medicare's free software.

2.2 Trading Partner and Supplier Enrollment

A CEDI Trading Partner is any entity (supplier, billing service, clearinghouse, or software vendor) that transmits electronic data to or receives electronic data from CEDI.

To enroll with CEDI to send NCPDP claims, complete the on-line enrollment forms located on the CEDI website (https://cedi.wellpointfederal.com).

- *CEDI Enrollment Agreement Form:* Used to enroll in electronic claim transmission.
- *CEDI Trading Partner Action Request Form:* Used to apply for a trading partner/submitter ID to log in and send claim files. This form is also used to indicate the type of transactions requested for the trading partner/submitter ID.

- *CEDI Supplier Authorization Form:* Used to authorize a third-party biller or clearinghouse to send the electronic claims for the supplier.
- *CEDI ERA Enrollment Form:* Allows a provider to receive ERA from the Common Electronic Data Interchange (CEDI). Enrolls both the NPI and PTAN for Electronic Remittance Advice (ERA). This form is required for new ERA enrollments and changes to an existing ERA setup if the form is not on file with CEDI.

CEDI enrollment documents are completed and submitted on-line. CEDI enrollment forms do **not** need to be faxed.

Submitted enrollment forms will be issued Packet ID (PID) numbers which will be assigned once the enrollment packet is submitted electronically. The PID will also be e-mailed to the e-mail address provided on the enrollment packet. The PID number can be used to track the submitted enrollment packet.

When CEDI enrollment packet is submitted, an acknowledgment e-mail will be generated and sent back to the e-mail address entered on the packet. Once the request has been approved and processed, a setup confirmation will be sent via e-mail. The trading partner/submitter must contact the CEDI Help Desk by telephone to obtain their initial password.

Instructions on how to complete the enrollment packet are included on the CEDI website (https://cedi.wellpointfederal.com).

2.3 Vendor Testing and Approval

NCPDP is the HIPAA approved format to submit DME MAC retail pharmacy drug claims. As of January 1, 2012, retail pharmacies transmitting retail drug claims electronically may use the NCPDP Batch Standard IG version 1.2 and Telecommunication Standard IG version D.0. The NCPDP standard is accepted for retail pharmacy drug claims only. Claims for supplies and services must be billed using the ANSI X12 837 claims format in a separate transmission from the NCPDP retail drug claims.

A pharmacy electing to use a third party for translation services is liable for those costs.

Software vendors and in-house programmers not previously approved to submit NCPDP claims who are planning to exchange electronic retail pharmacy drug claims in the NCPDP format with Medicare must schedule testing with CEDI prior to transmission of their first actual retail drug claim file. There is no charge for this system testing.

Retail pharmacies and third parties who elect to use a software vendor that has been approved for NCPDP by CEDI are not required to test.

To begin testing NCPDP transactions with CEDI:

1. Test files for NCPDP should be submitted under the Test Vendor Login ID (begins with a V08). If you are not sure you have a Vendor Test ID, send an email to CEDI Help Desk (cedihelpdesk@anthem.com)

requesting the ID be sent to you. If it is discovered you do not have a Vendor Test Login ID number, you will be asked to complete the Trading Partner Test ID Request form in order to obtain one.

2. You will be assigned a contact at CEDI who will work with you as you test the NCPDP transaction.
3. You will be asked to inform your testing contact when a test file is being submitted.
4. Test files cases should contain no more than 25 claims and contain real data.
5. All test claims will receive a Transmission Response indicating whether they have passed or rejected.
6. If test claims pass, the vendor will receive an email asking how they want their vendor information to appear on the Approved Entity list on the CEDI website (https://cedi.wellpointfederal.com).
7. If test claims do not pass, the vendor will be asked to fix the errors and send another test file in until they have successfully passed testing.
8. Test results will be provided to the vendor within three business days. During HIPAA version transitions, this time-period may be extended, not to exceed ten business days.

2.3.1 Trading Partner Testing

Trading Partners do not need to test if they are using an approved software vendor. Trading Partners may go to CEDI website (https://cedi.wellpointfederal.com), click on the Resources, then click on the Approved Entities List to see if their vendor has passed testing or to locate an approved vendor.

3 National Council for Prescription Drug Programs Implementation

NCPDP is the HIPAA approved format to submit DME MAC retail pharmacy drug claims. Each retail pharmacy transmitting retail drug claims electronically may use the NCPDP Batch Standard IG version 1.2 in conjunction with Telecommunication Standard IG version D.0 – commonly referred to collectively as “NCPDP D.0”. The NCPDP standard will be accepted for retail pharmacy drug claims only. Claims for supplies and services must be billed using version 5010 of the ASC X12 837 claims format and must be submitted in a separate transmission from the NCPDP retail drug claims.

The NCPDP Batch Standard Implementation Guide (IG) version 1.2, Telecommunication Standard Implementation Guide (IG) version D.0, External Code List (ECL) and Data Dictionary are available for NCPDP members to download from the NCPDP website (https://www.ncpdp.org). The NCPDP Version D Editorial Document is freely available at NCPDP website – HIPAA Information (https://www.ncpdp.org/Resources/HIPAA-Information).

4 Connectivity with the Payer / Communications

4.1 Process Flows

The following diagrams show how production and test transactions flow into and out of CEDI.

Figure 1. CEDI Production Transaction Flows

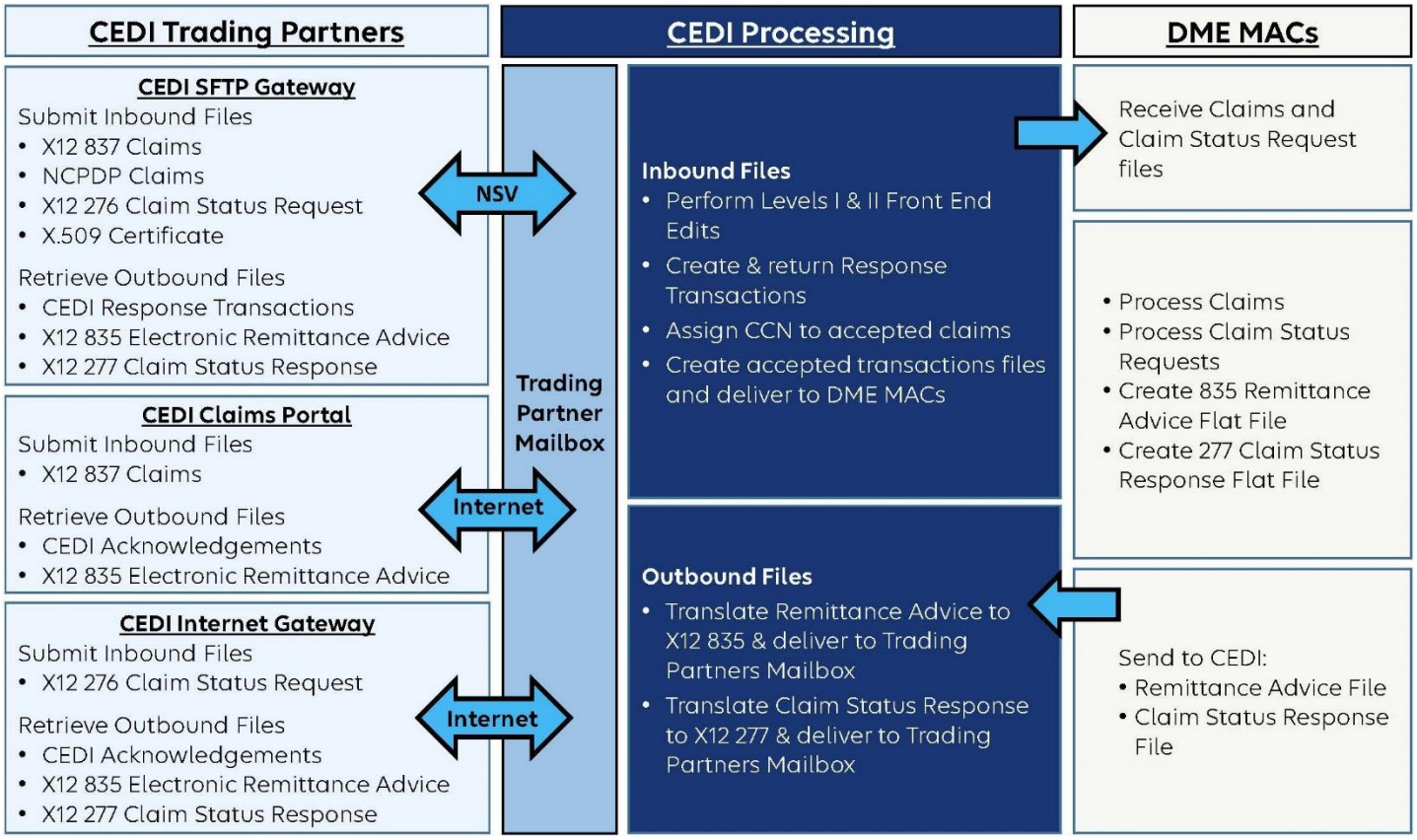
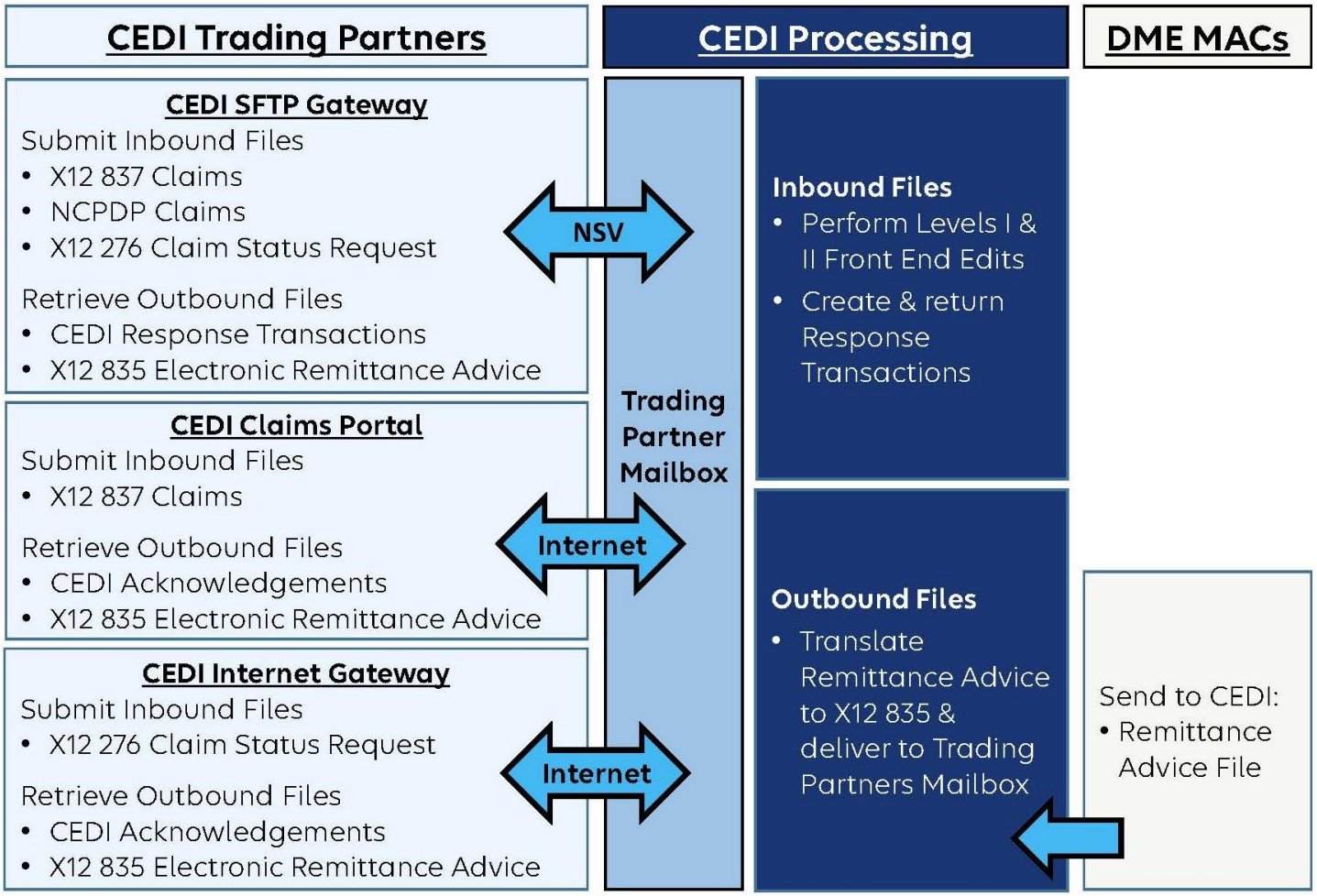


Figure 2. CEDI Test Transaction Flows



4.2 Transmission Administrative Procedures

All CEDI Trading Partners must use a Network Service Vendor (NSV) to connect to the CEDI Gateway to exchange electronic transactions. The NSV provides a secure, continuous connection for CEDI Trading Partners. The NSVs who provide connectivity to CEDI are listed on the CEDI website (https://cedi.wellpointfederal.com).

To receive additional information on the services provided from these network service vendors and pricing structures, please use the contact information provided on the CEDI website (https://cedi.wellpointfederal.com).

4.2.1 Re-transmission Procedures

CEDI does not require any identification of a previous transmission of a claim. All claims sent should be marked as original transmissions.

4.3 Communication Protocols

The CEDI sFTP Gateway can be used for all transactions – X12 837P claims, NCPDP claims, X12 276/277 Claim Status Request/Claim Status Response, X12 835 Electronic Remittance Advice, and the associated response transactions and reports. CEDI Trading Partners must use a Network Service Vendor (NSV) to connect to the CEDI sFTP Gateway using their CEDI assigned ID and password. NSVs provide a secure, continuous connection for CEDI Trading Partners. To view the list of NSVs who provide connectivity to CEDI and obtain additional information on the services and pricing they offer, please use the contact information on the Telecommunications page of the CEDI website (https://cedi.wellpointfederal.com/Telecommunications).

The CEDI Internet Gateway supports CAQH CORE compliant exchanges of the 276/277 Claim Status Request/Response and 835 ERA transactions using HTTP+MIME or SOAP+WSDL Message Envelope Standards and X.509 Certificates for authentication. **Note:** The CEDI Internet Gateway does not support the following transactions: X12 837 Claims, NCPDP Claims, or real time 276/277 Claim Status Request/Response and the CEDI Internet Gateway will reject these transactions.

CAQH CORE Phase I, II, & III Operating Rules and communication protocol specifications are located on the CAQH CORE website (https://www.caqh.org/core/operating-rules).CEDI Trading Partners have one mailbox for all their inbound and outbound CEDI transactions and are not restricted to using only the sFTP or only the Internet Gateway for their 276/277 or 835 transactions. Both Gateways are merely methods of accessing the Trading Partner's CEDI mailbox to send and retrieve transactions. For example, it is possible to retrieve TA1, 999, & 277 Claim Status Responses via the Internet Gateway for 276 Claim Status Requests that were originally submitted via the sFTP Gateway and vice versa depending on the commands used upon connection.

Trading Partners who elect to use the CEDI Internet Gateway for the 276/277 and/or 835 transactions are required to obtain an X.509 Certificate to be used for the authentication process. To upload the X.509 Certificate, the Trading Partner will connect and login to the sFTP Gateway using their CEDI assigned login ID and password. CEDI will return a Transaction Acknowledgement Report (TRN) indicating if the X.509 Certificate was accepted or rejected by CEDI. If the Certificate is rejected, the Trading Partner must correct the errors and resubmit the Certificate before they can begin using the CEDI Internet Gateway. When the X.509 Certificate is accepted, the Trading Partner is approved to use the CEDI Internet Gateway.

Trading Partners must submit a new X.509 Certificate to CEDI using the same process as above prior to the expiration of their current Certificate or if their current Certificate has been compromised.

For HTTP+MIME connections to the CEDI Internet Gateway, use the URL:
(https://cedicore.wellpointfederal.com/CoreBatchGateway/TransactionSocketServlet)

For SOAP+WSDL connections to the CEDI Internet Gateway, use the URL:
(https://cedicore.wellpointfederal.com/CoreBatchGateway/soap/coreservice)

The Telecommunications page of the CEDI website (https://cedi.wellpointfederal.com/Telecommunications) provides additional information regarding the two CEDI Gateways, a listing of the CEDI approved Network Service Vendors for connection to the CEDI sFTP Gateway, and a listing of the CEDI approved Certificate Authorities for issuance of the X.509 Certificates to access the CEDI Internet Gateway.

4.4 Security Protocols

All Trading Partners must adhere to CMS information security policies; including, but not limited to, the transmission of electronic claims, claim status, receipt of the remittance advice, or any system access to obtain beneficiary PHI and/or eligibility information. Violation of this policy will result in revocation of all methods of system access. CEDI is responsible for notifying all affected Trading Partners as well as reporting the system revocation to CMS.

EDI transactions submitted by unauthorized Trading Partners will not be accepted by CEDI. Trading Partners must enroll with CEDI to obtain a Trading Partner identification number and must contact the CEDI Help Desk by telephone to obtain their initial password (refer to Section 2.2). The Trading Partner will be prompted to change the initial password at the time of the first connection to CEDI. Trading Partners must protect password privacy by limiting knowledge of the password to key personnel and changing the password when there are changes to personnel.

Passwords will expire every 60 days, and thus required to be changed at least every 60 days but may be changed more frequently at the discretion of the Trading Partner. CEDI offers a self-service password reset portal to aid in the process of resetting passwords.

Guidelines for Creating a "Good" Password

Most security breaches are a direct result of users selecting "bad" passwords. The selection of a "good" password is critical to ensuring the security and integrity of your health care information. A good password is one that is difficult for others to guess and yet is easily remembered by the user.

Passwords will expire every sixty days.

The following basic guidelines should help when creating a password:

DO

- Must be exactly eight (8) characters in length
- Must include both alphabetic and numeric characters in the password
- Must contain at least 1 uppercase and 1 lowercase letter
- Must contain a special character; for example: ! $ %
- Passwords are case sensitive
- Must contain a minimum of four (4) characters different than the previous password
- Must be different than the last nine (9) passwords.

DON'T

- Do not use English defined words

- Do not use your user ID or any permutation of it as the password
- Do not use your company name, department name, or any permutation of it as a password
- Do not use your name or initials in any form
- Do not use family members or pets as part of the password
- Do not use swear words or obscene words; they're among the first words tried when guessing passwords
- Do not write down your password
- Do not reuse your password
- Do not store your password in scripts, files, or applications unless compensating controls are in place
- Do not use any form of date such as month, day, year, etc.

5 Contact Information

5.1 CEDI Customer Service and Technical Assistance

For CEDI customer service and technical assistance, contact the CEDI Help Desk at:

- Phone: 866-311-9184
- E-mail: CEDI Help Desk (cedihelpdesk@anthem.com)
- The CEDI Help Desk is open Monday through Friday from 9:00 a.m. ET through 6:00 p.m. ET.
- The CEDI Help Desk is closed Thursdays from 3:00 p.m. ET through 4:00 p.m. ET for training.
- Information on closures and holidays is also available on the CEDI website – Important Events (https://cedi.wellpointfederal.com/Important-Events)CEDI website (https://cedi.wellpointfederal.com)

5.2 DME MAC Supplier Service

DME MAC Jurisdiction Contact Information

Jurisdiction A – Noridian Healthcare Solutions

Noridian Healthcare Solutions supports the following states: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT

Customer Service: 866-419-9458

Automated Interactive Voice Response (IVR) System: 866-419-9458

Noridian Healthcare Solutions JA DME (https://med.noridianmedicare.com/web/jadme)

Jurisdiction B – CGS Administrators LLC

CGS Administrators LLC supports the following states: IL, IN, KY, MI, MN, OH, WI

Provider Contact Center: 866-590-6727

Automated IVR System: 877-299-7900

CGS Administrators LLC (https://www.cgsmedicare.com/jb)

Jurisdiction C – CGS Administrators LLC

CGS Administrators LLC supports the following states: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VA, VI, and WV

Customer Service: 866-270-4909

Automated IVR System: 866-238-9650

CGS Administrators LLC (https://www.cgsmedicare.com/jc)

Jurisdiction D – Noridian Healthcare Solutions

Noridian supports the following states: AK, AS, AZ, CA, GU, HI, ID, IA, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY

Supplier Contact Center: 877-320-0390

Automated IVR System: 877-320-0390

Noridian Healthcare Solutions JD DME (https://med.noridianmedicare.com/web/jddme/)

Questions regarding assigning the National Provider Identifier (NPI) are addressed by the National Plan & Provider Enumeration System (NPPES):

- Phone: 800-465-3203
- Email: NPPES Customer Service (customerservice@npienumerator.com)
- NPPES (https://nppes.cms.hhs.gov/NPPES/Welcome.do)

Questions regarding the assignment of the Durable Medical Equipment Provider Transaction Access Number (PTAN) are addressed by the National Provider Enrollment Eastern Region (NPEAST) or Provider Enrollment Western Region (NPWEST):

- **NPEAST (Novitas Solutions)**

States: Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Wisconsin, District of Columbia, Puerto Rico, US Virgin Islands

- Phone: 866-520-5193
- NPEAST Novitas Solutions (https://www.novitas-solutions.com)

- **NPWEST (Palmetto GBA)**

  States: Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands

  - Phone: 866-238-9652
  - NPWEST Palmetto GBA (https://www.palmettogba.com)

Questions regarding the Medicare provider and supplier enrollment process capturing the provider/supplier information from the CMS-855 family of forms and creating the NPI crosswalk entries are addressed by the Provider Enrollment, Chain and Ownership (PECOS):

- Phone: 866-484-8049
- PECOS (https://pecos.cms.hhs.gov/pecos/login.do)

6 Control Segments / Envelopes

Details of the Medicare usage of the NCPDP D.0 records are covered under Section 8.2 Trading Partner Agreement.

7 Acknowledgements and Reports

CEDI will return the TRN Acknowledgement and the NCPDP Transmission Response Report showing accepted and rejected files and/or claims.

7.1 TRN Acknowledgements

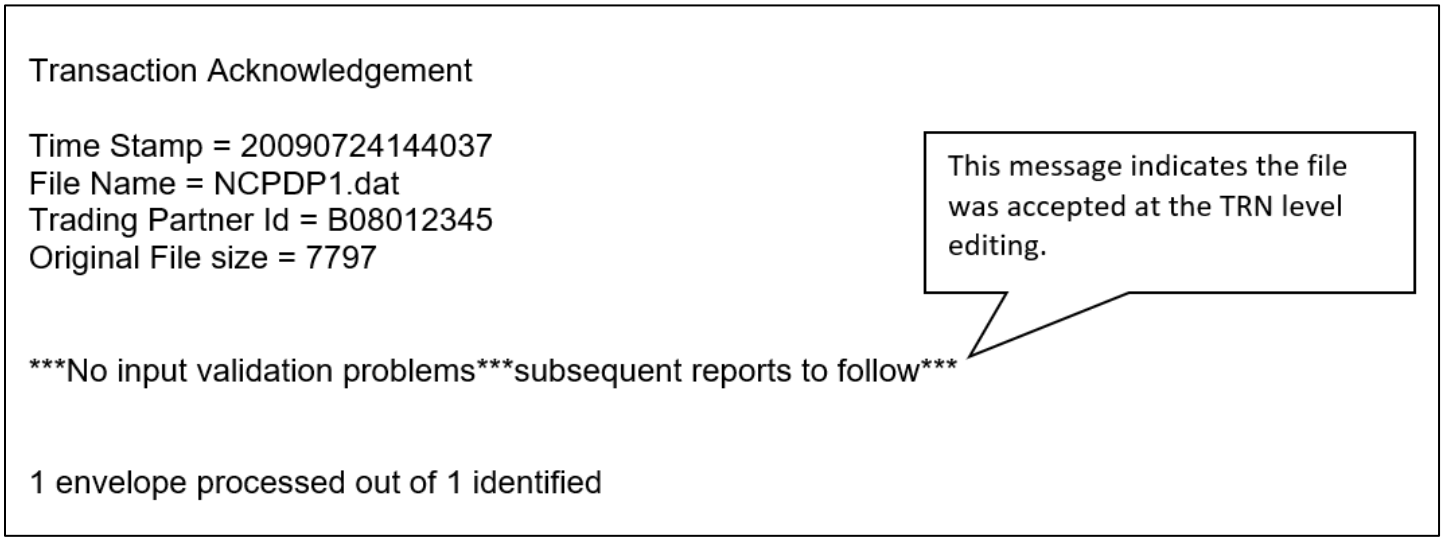
A TRN Transaction Acknowledgment will be generated as the first level of reporting to indicate the file received was either (1) in good enough form to be recognized as an NCPDP file and will be passed on to the next level of editing, or (2) not recognized as an NCPDP file and cannot be passed on to the next level of editing or (3) that the format/version being submitted is not valid for the trading partner submitting the file.

The TRN includes a heading indicating “Transaction Acknowledgment”, as well as the Timestamp, File name, Trading Partner ID, file size, indication of whether file format was recognized, and indication that subsequent reports will follow (if applicable).

Report Name: The TRN report name begins with “trn” followed by a sequence number (ex. trn00424.txt).

Timeframe: The TRN report is typically delivered immediately back to the Trading Partner. If the TRN is not received within two hours, contact the CEDI Help Desk at 1-866-311-9184.

Figure 3. TRN Example



7.2 NCPDP Transmission Response Report

General Information

- The NCPDP Transmission Response is the second level of acknowledgment for NCPDP vD.0 claims and will be used to report acceptance or rejection of the batch file as well as acceptance or rejection of each individual claim within the batch. If the claim file submitted contains errors, the response file can denote up to 5 errors per claim – based on all levels of editing. If the claims contain no errors at any level, the response file will denote the Medicare claim control number (CCN) and the DME MAC jurisdiction to which the claim will be distributed.
- The Transmission Response is a codified electronic response file. The vendor who maintains your NCPDP claim billing software will need to be engaged to ensure these response files will be understandable to the end user in your billing office.
- Multiple claim batches cannot be sent within the same physical file. In the event multiple claim batches are received within the same physical file, only one Transmission Response file will be returned notating the error “Multi Batches Not Allowed”.

Report Name: The NCPDP Transmission Response file name begins with “RESP” followed by the input file name and a sequence number

Example: Input File Name: NCPDP1

Report Name: RESP.NCPDP1.0025

Timeframe: The NCPDP Transmission Response is typically delivered immediately back to the Trading Partner. If the NCPDP Transmission Response is not received within two hours, contact the CEDI Help Desk at 1-866-311-9184.

Matching the Transmission Response File to Original Input

The 806-5C batch number from the batch header record on the originally submitted file will be returned back on the Transmission Response in the 806-5C field in the batch header record. Consequently, the 880-K5 Transaction Reference Number from each batch detail (G1) record will be returned back on the Transmission Response in the 880-K5 field in the batch detail (G1) record.

Understanding the Transmission Response

There can be various ‘views’ of the Transmission Response generated based on the original claim reporting scenario. Consequently, based on the NCPDP standard, there are multiple fields within the response which will denote the acceptance or rejection at various levels within the transaction. However, Medicare has also incorporated use of the 504-F4 Response Message field in an effort to clearly denote the overall designation for each claim. The following exhibits are intended to portray the varying “views” response statuses within each level of the response file.

All Claims Accepted Example

The following is the NCPDP Transmission Response for a batch of four claims where all claims are accepted. Each claim will have an AM20 segment with the “F4” field tag followed by acronym “CCN”, followed by the DME MAC destination payer, followed by the actual Claim Control Number (CCN).

(**Note:** The following example does not depict the actual hex characters used as separators to parse the data. Refer to the NCPDP guides for hex character information).

Color Key Figure 4: Yellow (Bold) = Segment, Blue (Italic) = Field, Green (Border) = Field Value

Figure 4. All Claims Accepted Example

```
00R16013                          211800020100716165 7T12TP00001                    G11111111111D0B11A011234567893
20100405AM20F4CCN16013YYJJJBBBBSS000AM25C2111111111AAM29CAJOHN
TESTCBSMITHLASTC419400523AM21ANC7F018F8663119184AM22EM1D2102737                   G12222222222D0B11A011234567893
20100405AM20F4CCN17013YYJJJBBBBSS000AM25C2111111111AAM29CAJANE
TESTCBDOELASTC419410624AM21ANC7F018F8663119184AM22EM1D2102737                     G13333333333D0B11A011234567893
20100405AM20F4CCN18003YYJJJBBBBSS000AM25C2111111111AAM29CAJOEY
TESTCBJONESLASTC419420725AM21ANC7F018F8663119184AM22EM1D2102737                   G14444444444D0B11A011234567893
20100405AM20F4CCN19003YYJJJBBBBSS000AM25C2111111111AAM29CAJADE
TESTCBMILLERLASTC419430826AM21ANC7F018F8663119184AM22EM1D2102737
9921180000000000006
```

Claims Rejected Example

The following is the NCPDP Transmission Response for a batch containing two claims where both claims were rejected. The “FA” field in the AM21 segment will reflect the number of reasons for rejection. The “FB” field will reflect the reject code (reason for rejection). There can be up to five reject codes on the response.

Refer to Appendix A of the NCPDP ECL for a listing of the reject codes.

With this example, the first claim has no errors at the “transmission level” (i.e. claim level), however, there are two errors at the “transaction level” (i.e. line item level). Therefore, although the 501-F1 Header Response Status = “A”, the entire claim is being rejected by Medicare as denoted by the “CLAIM REJECTED” reference in the AM20 504-F4 Message field. The second claim contains errors at both “transmission” (i.e. claim) and “transaction” (i.e. line) levels; therefore, the 501-F1 Header Response Status = “R” as well as the message “CLAIM REJECTED” in the AM20 504-F4 Message field.

(**Note:** The example below does not depict the actual hex characters used as separators to parse the data. Refer to the NCPDP guides for hex character information).

Color Key Figure 5: Yellow (Bold) = Segment, Blue (Italic) = Field, Green (Border) = Field Value

Figure 5. Claims Rejected Example

```
00R16013                          1001000201007161657T12TP00001                   G12222222222D0B11A011234567893
20090415AM20F4CLAIM
REJECTEDAM25C2111111111AAM29CAJOHNFIRSTCBSMITHLASTC419400527AM2
1ANRFA01FBE37F018F8663119184AM22EM1D2102737
G12222222222D0B11R011234567893     20090415AM20F4CLAIM REJECTED
AM21ANRFA02FBK5FBE37F018F8663119184
9910010000000000004
```

Rejected Batch Example

When an entire batch of claims is being rejected due to batch level errors, the 880-K6 Transmission Type in the Response Batch Header will = “E” (Error), and the Batch Trailer record will contain a readable message in field 504-F4 denoting the reason for rejection.

(**Note:** The example below does not depict the actual hex characters used as separators to parse the data. Refer to the NCPDP guides for hex character information).

Figure 6. Rejected Batch Example

```
00E16013                  21200002010071709l5T12TP00001
9921200000000000000041-DUPLICATE FILE
```

8 CCI Additional Information

8.1 Implementation Checklist

Vendors and In-House Programmers

- Obtain the *NCPDP Batch Standard Implementation Guide (IG) version 1.2, Telecommunication Standard Implementation Guide (IG) version D.0, External Code List (ECL)* and *Data Dictionary*. These are available for NCPDP members to download from the NCPDP website (https://www.ncpdp.org).
- Obtain the *NCPDP Version D Editorial Document* from NCPDP website – HIPAA Information (https://www.ncpdp.org/Resources/HIPAA-Information).
- Make necessary programming changes for NCPDP version D.0.
- Successfully test NCPDP version D.0 following "Section 2.3 Vendor Testing and Approval".
- Vendors will implement NCPDP D.0 for your customers.
- In-house programmers will begin using NCPDP D.0.

Suppliers Using a Vendor

- Contact your vendor to confirm they are ready to test NCPDP D.0 and when testing will be completed.
- Contact your vendor confirm the date they will move you to NCPDP D.0.
- If your vendor will no longer support NCPDP, contact software vendors listed on the CEDI Approved Entities List (https://cedienroll.wellpointfederal.com/approvedentities) to find a new vendor to support your submission of NCPDP version D.0 claims.

8.2 Trading Partner Agreement

This Trading Partner Agreement (TPA) is specific to processing of the inbound NCPDP claims transaction in the Wellpoint Federal CEDI processing system. The TPA provides additional documentation solely for the purpose of clarification. The TPA gives information to the Trading Partner that will simplify implementation and provide a successful submission and acceptance of the inbound claims transmission.

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification that directs the federal government to adopt national standards for automated transfer of certain health care data between health care payers, plans, providers, and clearinghouses. The final rule was published August 17, 2000, became effective October 16, 2000 and was fully implemented October 16, 2003.

Each retail pharmacy that transmits retail drug claims electronically must use the National Council for Prescription Drug Programs (NCPDP) Telecommunication standard Version D.0 and Batch Standard Version 1.2 by January 1, 2012. The NCPDP standard will be accepted for DME MAC retail pharmacy drug claims only. DME MAC claims for supplies and services must be billed using version 5010A1 of the ASC X12 837 claims format and must be submitted in a separate transmission from the NCPDP retail drug claims.

The NCPDP Batch Standards IG, Telecommunication Standard IG, External Code List (ECL), and Data Dictionary can be obtained at the NCPDP website (https://www.ncpdp.org) for a fee.

This document includes references to fields/values based on the June 2010 version of the ECL. Changes to this document will take place in conjunction with any future changes being made by Medicare to accommodate modifications to the ECL.

Note: Nonretail pharmacies are to bill using the ANSI X12 837 5010A1.

CEDI will generate a local "TRN" and NCPDP Standard Transmission Response file to acknowledge all retail pharmacy claim bills submitted in NCPDP version D.0. Refer to the CEDI NCPDP Front-End Manual – available on the CEDI website (https://cedi.wellpointfederal.com) for detailed information.

National Drug Code

Pharmacies are required to transmit the national drug code (NDC) in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy. The NDC replaces the Healthcare Common Procedure Coding System (HCPCS) codes for retail pharmacy drug transactions billed to DME MACs via the NCPDP standard.

Note: DME MACs must accept NDC codes for oral anti-cancer drugs billed electronically and via paper. All other paper and electronic ASC X12 837 claims are to be billed using HCPCS.

General Requirements

1. This guide was created to provide the CEDI and DME MAC specific requirements to suppliers and Trading Partners for creating an incoming NCPDP D.0 file. This document contains DME MAC valid values for fields and lists only the segments and fields which could apply to a DME MAC claim.

2. Suppliers will create the Billing Request transaction (value "B1" in field 103-A3 of the Transaction Header segment) as required in the NCPDP standard and as clarified within this document.

3. Only segments and fields that are “Mandatory” (M) in the standard, or shown as “Required” (R) or “Situational” (S) should be sent. If a Segment or Field is marked as “Situational”, it is only sent if the data condition stated applies. If a data condition is not met, it need not be submitted for Medicare claim bills. If a claim is to be sent to another payer by Medicare for secondary payment, and a situational field applies to the secondary payer, it should be included in the claim sent to Medicare even if the situation does not apply to Medicare. With the exception of the AM14 Additional Documentation fields, any other optional fields not listed in this document can also be included on the claim for purposes of forwarding that data onto the subsequent payer.

4. Fields designated as Not Used for the D.0 Telecommunication Standard, B1 Claim Billing transaction will be ‘ignored’ and not sent forward to secondary payers.

5. Medicare will only accept and process Batch Transactions using the NCPDP Batch Standard version 1.2 with the Telecommunication Standard version D.0. The Batch Standard is a file transmission of one header, one or more detail records, and one trailer (multiple batches within one physical file will be rejected). The detail records are built using the Telecommunication Standard version D.0, where one detail record is submitted for each claim transaction.

6. Medicare will only accept and process Billing Transactions (value B1 in the Transaction Header Segment, Transaction Code field 103-A3) with the Rx Billing indicator “1” in the Prescription/Service Reference Number Qualifier field 455-EM.

7. The following segments are required for Medicare processing:

   Patient Segment (AM01)

   Insurance Segment (AM04)

   Prescriber Segment (AM03)

   Claim Segment (AM07)

   Pricing Segment (AM11)

   Clinical Segment (AM13)

8. Suppliers may submit up to four detail record transactions (i.e. AM07 Claim Segments) per detail record transmission except for compound billings. Only one detail record transaction (i.e. one AM07 Claim Segment) per detail record transmission is allowed when billing for a multi-ingredient prescription.

9. The Facility Segment (AM15) must be submitted when the Place of Service field 307-C7 is not = 12 (home).

10. The Coordination of Benefits/Other Payments Segment (AM05) and the Compound Segment (AM10) are to be used for Medicare only when those reporting scenarios apply to the claim.

11. The Additional Documentation segment (AM14) must not be submitted. If submitted, the segment and associated fields will be subjected to IG level editing in addition to being rejected for submission.

12. The Pharmacy Provider (AM02), Worker's Comp (AM06), Coupon (AM09), and Narrative (AM16) segments may be reported as deemed necessary by the submitter. If submitted, these segments and associated fields will be subjected to IG level editing.

13. Fields defined by a related qualifier field must contain valid and appropriate information for the qualifier value reported.

14. Segment, Group, and Field Separators defined in the NCPDP standard must be used to parse all data.

15. The transaction must adhere to the standard conventions as stated in Section 33 of the NCPDP Telecommunication Standard Implementation Guide version D.0.

16. As per the Telecommunication standard IG, lower case characters are not allowed.

17. ZIP Codes must not include hyphens and positions 6 through 9 must not be all zeros.

18. Medicare will only process a format of 9(5)V99 for monetary fields rather than the maximum format of 9(7)V99 as specified in the IG. A monetary amount of 9(7)V99 would far exceed Medicare coverage parameters. Medicare will reject monetary entries larger than 9(5)V99 as they are assumed to be data entry transcription or another manual error.

    Note: Under HIPAA compliancy rules, plans are permitted to reject transactions that exceed coverage parameters, even if compliant with IG requirements.

Compound Drugs

Compounded drugs will be billed using the Compound Segment (AM10) in the NCPDP standard. Compounded Prescription guidance includes:

1. The Route of Administration field (995-E2) will be used to distinguish the Nebulizer Drug compounds from other drug compounds and will indicate the route of the complete compound mixture. The valid Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT®) codes that Medicare will accept in this field are:
    - 112239003 – "By inhalation (route)" (i.e. Nebulizer Compounds)
    - 26643006 – "Oral route" (i.e. Immunosuppressive Compounds)

2. The sum of the Compound Ingredient Drug Cost field (449-EE) will equal the Gross Amount Due field (430-DU) minus the Dispensing Fee Submitted field (412-DC) and the Incentive Amount Submitted (438-E3).

3. Compounds for inhalation drugs should only be used for multiple active ingredients. For single active ingredients, use the claim segment.

Parenteral Nutrition Products

Parenteral nutrition claims must be billed on the ASC X12 837 using HCPCS codes.

Enteral Nutrition Products

Enteral nutrition claims must be billed on the ASC X12 837 using HCPCS codes.

End-Stage Renal Disease

End Stage Renal Disease (ESRD) drug claims must be billed on the ASC X12 837 using HCPCS codes.

Epoetin

Epoetin (EPO) claims associated with ESRD must be billed on the ASC X12 837.

Non-ESRD EPO must be billed either on the NCPDP by retail pharmacists or on the ASC X12 837 by professional pharmacists.

Home Infusion Products

Claims for home infusion products must be billed on the ANSI X12 837 using the HCPCS codes to identify the drug and related supply. Home infusion pharmacies are professional pharmacies and will not use the NCPDP format for submitting claims to Medicare.

Medigap

The following fields must be submitted in order to allow Medicare to determine that a beneficiary has Medigap coverage:

1. For coordination of benefits (COB) related to Medigap, the Patients Medigap Plan ID Number will be submitted in the Medigap ID field (359-2A) in the Insurance segment.

2. The Medigap Insurer ID (COBA number) will be submitted in the Group ID (301-C1) in the Insurance segment.

   Note: Medigap takes priority when there is dual Medigap and Medicaid in a claim-based situation.

Medicaid

For Medicaid crossover claims, the Medicare beneficiary's identification number must be entered in the Cardholder ID field (302-C2) if the eligibility file received from Medicaid, or the trading partner does not have a Medicaid Beneficiary ID in the Supplemental ID field. If there is a Medicaid Beneficiary ID number in the

Supplemental ID field, the Medicaid Beneficiary ID number must be entered in the Cardholder ID field (302-C2).

In addition, the two character state code indicating where Medicaid coverage exists must be submitted in the Medicaid Indicator field (360-2B) in the Insurance segment.

Medicare Secondary Payer (MSP) Claims

When Medicare is the secondary payer (MSP), pharmacies must complete the following fields in order for Medicare to calculate the Other Payer Allowed and Obligated to Accept amounts:

1. The Original Submitted Amount will be sent in the Gross Amount Due (430-DU) on the Pricing segment;

2. The Other Payer Paid Amount Qualifier field 342-HC should be reported with qualifier value “07” (drug benefit) in conjunction with the associated amount in the Other Payer Paid Amount field 431-DV.

3. The Other Payer Responsibility Amount Qualifier field 351-NP should be reported with qualifier value “01” in conjunction with the associated amount in the Other Payer Responsibility Amount field 352-NQ to indicate deductible. To indicate coinsurance, field 351-NP should be reported with qualifier “07” in conjunction with the associated amount in 352-NQ.

Partial Fills

Medicare does not process the partial and completion billing for prescriptions as described in the NCPDP Telecommunication Standard Implementation Guide. The Dispensing Status field 343-HD must not be used for Medicare claim bills. Instead, pharmacies must submit the Actual Quantity Dispensed in field 442-E7 regardless of whether the prescription is designated within the pharmacy system as a partial or completion of a partial fill.

Quantity Dispensed

Medicare requires the Quantity Dispensed in the 442-E7 field of the AM07 segment to be in the format 9(7)V999. Quantities must be submitted with additional values to the right of the implied decimal. The actual decimal point is not submitted.

For example:

- The quantity “1” would be submitted as “1000”
- The quantity “240” would be submitted as “240000”
- The quantity “30.5” would be submitted as “30500”

9 Medicare NCPDP Version D.0 Payer Sheet

Usage requirements:

M = Mandatory in Standard

R = Required for Medicare implementation

S = Situational usage as defined

9.1 Request Claim Billing Transaction Payer Sheet

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 2. Request Claim Billing Transaction Payer Sheet – Batch Header Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	00	M	None
880-K6	Transmission Type	T, R, E	M	Medicare only accepts “T” T = Transaction
880-K1	Trading Partner ID	[Submitter ID]	M	Enter the Trading Partner (Submitter) ID number assigned by CEDI
806-5C	Batch Number	[Batch Number]	M	This number must match the Batch Number (806-5C) in the Batch Trailer
880-K2	Creation Date	[Date]	M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time	[Time]	M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
102-A2	Version/Release Number	12	M	The batch version number must be "12" for NCPDP Batch Standard Version 1.2
880-K7	Receiver ID	16013, 17013, 18003, 19003	M	DME MAC Contractor ID. Any of the IDs below may be submitted to CEDI regardless of the DME MAC that will process the claim. 16013 – Jurisdiction A 17013 – Jurisdiction B 18003 – Jurisdiction C 19003 – Jurisdiction D

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 3. Request Claim Billing Transaction Payer Sheet – Batch Detail Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	G1	M	None
880-K5	Transaction Reference Number	[Reference Number]	M	When multiple detail records are submitted, the reference number must be unique within the batch file.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 4. Request Claim Billing Transaction Payer Sheet – Transaction Header Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
101-A1	BIN Number	[BIN Number]	M	Assigned BIN number for network routing Entering all zeros or all 9's is valid for Medicare.

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
102-A2	Version/Release Number	D0	M	The version/release number must be “D0” for NCPDP Telecommunication Standard Version D.0
103-A3	Transaction Code	B1	M	None
104-A4	Processor Control Number	[Control Number]	M	Submit the Patient Account Number
109-A9	Transaction Count	1,2,3,4	M	Indicate the number of lines for the claim. This must match the number of 111-AM(07) segments. **Valid Values for Non-Compound Claims:** • 1 – One Occurrence • 2 – Two Occurrences • 3 – Three Occurrences • 4 – Four Occurrences Valid Values for Compound Claims: • 1 – One Occurrence
202-B2	Service Provider ID Qualifier	01	M	01 – National Provider Identifier (NPI)
201-B1	Service Provider ID	[Service Provider ID]	M	Enter the NPI number **Note**: Only one Service Provider ID can be submitted in the Transaction Header Segment.
401-D1	Date of Service	[Date]	M	From Date of Service Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
110-AK	Software Vendor/Certification ID	[Software ID]	M	Must not be space filled.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 5. Request Claim Billing Transaction Payer Sheet – Patient Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	01	R	Patient Segment
304-C4	Date of Birth	[Date]	M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
305-C5	Patient Gender Code	0,1,2	R	Medicare only accepts values 1 and 2 **Valid Values:** • 1 – Male • 2 – Female
307-C7	Place of Service	01, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 25, 26, 31, 32, 33, 34, 41, 42, 49, 50, 51, 52, 53, 54, 55, 56, 57, 60, 61, 62, 65, 71, 72, 81, 99	R	Indicate the 2-digit place of service code representing where the patient received their pharmacy services.
310-CA	Patient First Name	[First Name]	R	None
311-CB	Patient Last Name	[Last Name]	R	None
322-CM	Patient Street Address	[Street]	R	None
323-CN	Patient City Address	[City]	R	None
324-CO	Patient State/Province Address	[State]	R	None

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
325-CP	Patient /Postal Zone	[ZIP Code]	R	The ZIP Code must be a valid 5 or 9 digit USPS ZIP Code and must not include hyphens or all zeros in 6th thru 9th positions.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 6. Request Claim Billing Transaction Payer Sheet – Insurance Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	04	M	Insurance Segment
302-C2	Cardholder ID	[MBI Number]	M	Enter Beneficiary Medicare Beneficiary Identifier (MBI) Must be 11 positions in the format of C A AN N A AN N A A N N where "C" represents a constrained numeric 1 thru 9; "A" represents alphabetic character A – Z but excluding S, L, O, I, B, Z; "N" represents numeric 0 thru 9; "AN" represents either "A" or "N".
312-CC	Cardholder First Name	[First Name]	R	Enter Beneficiary first name
313-CD	Cardholder Last Name	[Last Name]	R	Enter Beneficiary last name
301-C1	Group ID	[Group ID]	S	Used only when Patient has MEDIGAP coverage (Enter the COBA number)
306-C6	Patient Relationship Code	1	R	Medicare can only accept code “1”

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
361-2D	Provider Accept Assignment Indicator	Y, N	R	Indicate whether provider accepts assignment (**Note**: Medicare adjudication rules for Mandatory Assignment may cause the assignment indicator to be flipped from non-assigned to assigned during claim processing). **Valid Values:** • Y – Yes • N – No

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 7. Request Claim Billing Transaction Payer Sheet – Claim Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	07	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	Only value '1' is allowed for Claim Billing (B1) transactions. **Valid Value**: • 1 – Rx Billing
402-D2	Prescription/Service Reference Number	[Reference Number]	M	None
436-E1	Product/Service ID Qualifier	00, 03	M	00 – Used when compound is being submitted 03 – NDC, used for drugs and solutions
407-D7	Product/Service ID	[Product/ Service ID]	M	None
458-SE	Procedure Modifier Count	1 – 10	S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per NDC.
459-ER	Procedure Modifier Code	[Modifier Code]	S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per NDC.

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
442-E7	Quantity Dispensed	[Quantity]	R	Format = 9(7)V999 Zero is not valid
403-D3	Fill Number	0, 1-99	R	0 – Original dispensing 1-99 – Refill number
405-D5	Days Supply	[Amount]	R	Used for the amount of days the prescription is estimated to last. Zero is not valid
406-D6	Compound Code	1, 2	R	1 – No compound 2 – Compound
408-D8	Dispense As Written (DAW) / Product Selection Code	0, 1, 2, 3, 4, 5, 6, 7, 8, 9	R	• 0 = No Product Selection Indicated • 1 = Substitution Not Allowed by Prescriber • 2 = Substitution Allowed-Patient Requested Product Dispensed • 3 = Substitution Allowed-Pharmacist Selected Product Dispensed • 4 = Substitution Allowed-Generic Drug Not in Stock • 5 = Substitution Allowed-Brand Drug Dispensed as a Generic • 6 = Override • 7 = Substitution Not Allowed-Brand Drug Mandated by Law • 8 = Substitution Allowed-Generic Drug Not Available in Marketplace • 9 = Other (5.1)/Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed (D.0)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
414-DE	Date Prescription Written	[Date]	R	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
600-28	Unit of Measure	EA, GM, ML	S	To be reported when information could result in different coverage, pricing, or patient financial responsibility. **Valid Values:** • EA – Each • GM – Grams • ML – Milliliters
391-MT	Patient Assignment Indicator	Y, N	R	Indicate whether the patient assigned his/her benefits to the provider. Medicare will not assume the patient assigned benefits to the provider. **Valid Values:** • Y – Yes • N – No
995-E2	Route of Administration	112239003 26643006	S	For compounds, indicate the route of the complete compound mixture. **Note:** This field will be used to distinguish nebulizer compounds from other compounds. 112239003 – “By inhalation (route)” 26643006 – “Oral route”

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 8. Request Claim Billing Transaction Payer Sheet – Prescriber Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	03	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01	R	01 – National Provider Identifier
411-DB	Prescriber ID	[Prescriber ID]	R	Enter the NPI number **Note:** Only one Prescriber ID can be submitted in the Prescriber Segment
427-DR	Prescriber Last name	[Last Name]	R	None

The COB/Other Payments Segment is required when other insurance processing is involved.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 9. Request Claim Billing Transaction Payer Sheet – COB/Other Payments Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	05	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	1	M	Medicare accepts only one primary payer
338-5C	Other Payer Coverage Type	01, 02, 03, 04, 05, 06, 07, 08, 09	M	01=Primary 02=Secondary 03=Tertiary 04=Quaternary 05=Quinary 06=Senary 07=Septenary 08=Octonary 09=Nonary
339-6C	Other Payer ID Qualifier	blank, 01, 02, 03, 04, 05, 99	R	Use 05 for a Medicare-assigned identifier if known. (After National Plan ID is mandated, use only 01.)
340-7C	Other Payer ID	[Payer ID]	R	None

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
341-HB	Other payer amount paid count	1 – 9	S	None
342-HC	Other Payer Amount Paid Qualifier	01, 02, 03, 04, 05, 06, 07, 09, 10	S	07 – Drug Benefit to report the drug benefit amount paid by the other payer.
431-DV	Other Payer Amount Paid	[Amount]	S	If other payer processed claim, but made no payment, enter zero for paid amount The maximum value is 99999.99.
471-5E	Other Payer Reject Count	1 – 5	S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
472-6E	Other Payer Reject Code	NCPDP Reject Code values defined in ECL APPENDIX A1	S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
353-NR	Other Payer-Patient Responsibility Amount Count	1 – 25	S	Use only when patient has financial responsibility to share cost with other payer
351-NP	Other Payer-Patient Responsibility Amount Qualifier	blank, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13	S	Use only when patient has financial responsibility to share cost with other payer
352-NQ	Other Payer-Patient Responsibility Amount	[Amount]	S	Use only when patient has financial responsibility to share cost with other payer

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 10. Request Claim Billing Transaction Payer Sheet – Compound Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	10	M	Compound Segment

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
450-EF	Compound Dosage Form Description Code	blank, 01, 02, 03, 04, 05, 06, 07, 10, 11, 12, 13, 14, 15, 16, 17, 18	M	• Blank = Not Specified • 01 = Capsule • 02 = Ointment • 03 = Cream • 04 = Suppository • 05 = Powder • 06 = Emulsion • 07 = Liquid • 10 = Tablet • 11 = Solution • 12 = Suspension • 13 = Lotion • 14 = Shampoo • 15 = Elixir • 16 = Syrup • 17 = Lozenge • 18 = Enema
451-EG	Compound Dispensing Unit Form Indicator	1, 2, 3	M	1 – Each 2 – Grams 3 – Milliliters
447-EC	Compound Ingredient Component (Count)	1–25	M	Medicare will accept up to 25 ingredients in one compound mixture
488-RE	Compound Product ID Qualifier	03, 99	M	03 – NDC 99 – Other
489-TE	Compound Product ID	[Product ID]	M	Product identification of the ingredient used in the compound.
448-ED	Compound Ingredient Quantity	[Quantity]	M	The metric decimal quantity of the compound included in the compound mixture. Zero is not valid.

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
449-EE	Compound Ingredient Drug Cost	[Amount]	R	This will be used as the submitted amount when Medicare creates the service line for this ingredient
362-2G	Compound Ingredient Modifier Code Count	1 – 10	S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per compound ingredient.
363-2H	Compound Ingredient Modifier Code	[Modifier Code]	S	Used only when a procedure modifier code applies. Up to ten modifiers can be reported per compound ingredient.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 11. Request Claim Billing Transaction Payer Sheet – Pricing Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	11	M	Pricing Segment
409-D9	Ingredient Cost Submitted	[Amount]	R	Product component cost of the dispensed prescription. Included in Gross Amount Due.
412-DC	Dispensing Fee Submitted	[Amount]	R	Dispensing fee submitted by pharmacy. Included in Gross Amount Due. Zero is a valid value. Questions regarding the dispensing fee amount should be directed to the DME MAC that will process the claim.
433-DX	Patient Paid Amount Submitted	[Amount]	S	Beneficiary Paid Amount Used when the beneficiary or someone acting on behalf of the beneficiary made a payment for this service

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
438-E3	Incentive Amount	[Amount]	R	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Included in Gross Amount Due. Zero is a valid value. Questions regarding the incentive fee amount should be directed to the DME MAC that will process the claim.
430-DU	Gross Amount Due	[Amount]	R	The total submitted amount for this transaction. Zero is not valid for this field.

The Compound Segment is required when submitting a compounded formulation with multiple active ingredients.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 12. Request Claim Billing Transaction Payer Sheet – Clinical Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	13	M	Clinical Segment
491-VE	Diagnosis Code Count	1–5	R	A maximum of five diagnosis codes can be reported on each clinical segment.
492-WE	Diagnosis Code Qualifier	02	R	02-ICD-10
424-DO	Diagnosis Code	[Diagnosis Code]	R	Must be a valid ICD-10 code.

The Facility Segment is required when Place of Service field 307-C7 is other than ‘12’ (home).

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 13. Request Claim Billing Transaction Payer Sheet – Facility Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	15	M	Facility Segment
385-3Q	Facility Name	[Name]	R	Name identifying location of the service rendered.
386-3U	Facility Street Address	[Street]	R	None
388-5J	Facility City	[City]	R	None
387-3V	Facility State/Province	[State / Province]	R	None
389-6D	Facility Zip/Postal Zone	[ZIP Code]	R	The ZIP Code must be a valid 5 or 9 digit USPS ZIP Code and must not include hyphens or all zeros in 6th thru 9th positions.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 14. Request Claim Billing Transaction Payer Sheet – Batch Trailer Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	99	M	None
806-5C	Batch Number	[Batch Number]	M	This number must match the Batch Number (806–5C) in the Batch Header
751	Record Count	[Count]	M	None
504-F4	Message	[Message]	M	Must be at least space filled to maximum positions.

9.2 Claim Billing Accepted Response

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 15. Claim Billing Accepted Response – Batch Header Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	00	M	None
880-K6	Transmission Type	R	M	None
880-K1	Trading Partner ID (Submitter ID)	16013, 17013, 18003, 19003	M	DME MAC contractor ID number from original inbound batch header field 880-K7.
806-5C	Batch Number	[Batch Number]	M	Batch Number from original inbound batch header field 806-5C.
880-K2	Creation Date	[Date]	M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time	[Time]	M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test From the original inbound batch header field 702.
102-A2	Version/Release Number	12	M	The batch version number from original inbound batch header field 102-A2.
880-K7	Receiver ID	CEDI assigned Trading Partner ID	M	Receiver ID (Trading Partner ID) from original inbound batch header field 880-K1.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 16. Claim Billing Accepted Response – Batch Detail Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	G1	M	None
880-K5	Transaction Reference Number	[Reference Number]	M	Reference number from original inbound batch detail field 880-K5.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 17. Claim Billing Accepted Response – Transaction Header Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
102-A2	Version/Release Number	D0	M	The version/release number from original inbound Transaction Header field 102-A2.
103-A3	Transaction Code	B1	M	None
109-A9	Transaction Count	1,2,3,4	M	The transaction count from original inbound Transaction Header field 109-A9.
501-F1	Header Response Status	A = Accepted	M	None
202-B2	Service Provider ID Qualifier	Same value as in request	M	None
201-B1	Service Provider ID	Same value as in request	M	None
401-D1	Date of Service	Same value as in request	M	None

Table 18. Claim Billing Accepted Response – Response Message Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	20	R	Response Message Segment

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
504-F4	Message	CCN16013YYJJJ BBBBSS000 Where: Positions 1-3 are constant "CCN" Positions 4 – 8 equate to the DME MAC contractor ID to which the claim is being distributed, Positions 9 – 22 equate to the Medicare claim control number assigned to the accepted claim	R	Represents ultimate CEDI determination of acceptance or rejection. Accepted claims will reflect the DME MAC contractor ID where the accepted claim will be forwarded as well as the claim control number.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 19. Claim Billing Accepted Response – Response Insurance Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	25	M	Response Insurance Segment
302-C2	Cardholder ID	Same value as in request	R	None

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 20. Claim Billing Accepted Response – Response Patient Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	29	M	Response Patient Segment

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
310-CA	Patient First Name	Same value as in request	R	None
311-CB	Patient Last Name	Same value as in request	R	None
304-C4	Date of Birth	Same value as in request	R	None

Table 21. Claim Billing Accepted Response – Response Status Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	C	M	None
549-7F	Help Desk Phone Number Qualifier	01	R	None
550-8F	Help Desk Phone Number	8663119184	R	Format: • AAAEEENNNNXXXXXXXX • AAA=Area Code • EEE=Exchange Code • NNNN=Number • XXXXXXXX=Extension • CEDI Help Desk Phone Number: • 866-311-9184

Table 22. Claim Billing Accepted Response – Response Claim Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/ Service Reference Number Qualifier	1	M	Only value ‘1’ is allowed for Claim Billing (B1) transactions. 1 – Rx Billing
402-D2	Prescription/ Service Reference Number	Same value as in request	M	Leading zeros will be truncated on Response.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 23. Claim Billing Accepted Response – Batch Trailer Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	99	M	None
806-5C	Batch Number	[Batch Number]	M	Batch Number from original inbound batch header field 806-5C.0
751	Record Count	[Count]	M	Calculated number of records in batch (i.e. G1 data detail records plus header and trailer).
504-F4	Message	[Spaces]	M	Space filled to maximum positions.

9.3 Claim Billing Rejected Response

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 24. Claim Billing Rejected Response – Batch Header Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	00	M	None
880-K6	Transmission Type	R	M	None
880-K1	Trading Partner ID (Submitter ID)	16013, 17013, 18003, 19003	M	DME MAC contractor ID number from original inbound batch header field 880-K7
806-5C	Batch Number	[Batch Number]	M	Batch Number from original inbound batch header field 806-5C
880-K2	Creation Date	[Date]	M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time	[Time]	M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test From original inbound batch header field 702.
102-A2	Version/Release Number	12	M	The batch version number from original inbound batch header field 102-A2.
880-K7	Receiver ID	[CEDI assigned Trading Partner ID]	M	Receiver ID (Trading Partner ID) from original inbound batch header field 880-K1.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 25. Claim Billing Rejected Response – Batch Detail Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	G1	M	None
880-K5	Transaction Reference Number	[Reference Number]	M	Reference number from original inbound batch detail field 880-K5.

Table 26. Claim Billing Rejected Response – Response Transaction Header Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
102-A2	Version/Release Number	D0	M	From original inbound Transaction Header field 102-A2.
103-A3	Transaction Code	B1	M	None
109-A9	Transaction Count	1,2,3,4	M	The transaction count from original inbound Transaction Header field 109-A9. Note: If original count is not valid ECL value, response will reflect '1' and only one AM21 segment will be returned. If original count is a valid ECL value, but not equal to the actual count of transactions (i.e. AM07 segments), the response will reflect the actual calculated count of transactions and one AM21 segment will be returned for each recognized transaction (i.e. for each AM07 line item).

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
501-F1	Header Response Status	A or R	M	A = transmission accepted However, transaction rejected and overall claim will be rejected. R = Transmission rejected and transaction rejected and overall claim will be rejected). Message field 504-F4 in AM20 segment is ultimate CEDI determination of acceptance or rejection.
202-B2	Service Provider ID Qualifier	Same values as in request	M	None
201-B1	Service Provider ID	Same values as in request	M	None
401-D1	Date of Service	Same values as in request	M	None

The Response Insurance Segment is **not used** when there are only Transmission Level errors.

Table 27. Claim Billing Rejected Response – Response Insurance Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	25	M	Response Insurance Segment
302-C2	Cardholder ID	Same value as in request	R	None

The Response Patient Segment is **not used** when there are only Transmission Level errors.

Table 28. Claim Billing Rejected Response – Response Patient Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	29	M	Response Patient Segment
310-CA	Patient First Name	Same values as in request	R	None
311-CB	Patient Last Name	Same values as in request	R	None

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
304-C4	Date of Birth	Same values as in request	R	None

Table 29. Claim Billing Rejected Response – Response Message Segment (R)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	20	R	Response Message Segment
504-F4	Message	CLAIM REJECTED	R	Represents ultimate CEDI determination of acceptance or rejection. Rejected claims will always reflect constant message “Claim Rejected”.

Table 30. Claim Billing Rejected Response – Response Status Segment (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	21	M	Response Status Segment
112-AN	Transaction Response Status	R	M	**Note:** When there are transmission level errors, every identifiable transaction will be denoted with an “R”
510-FA	Reject Count	Maximum count of 5	R	None
511-FB	Reject Code	ECL Appendix A reject codes	R	Can be repeated up to 5 times
546-4F	Reject Field Occurrence Indicator	Maximum of 25	S	Required if a repeating field is in error to identify repeating field occurrence.
549-7F	Help Desk Phone Number Qualifier	01	R	None

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
550-8F	Help Desk Phone Number	8663119184	R	Format: AAAEEENNNNXXXXXXXX AAA=Area Code EEE=Exchange Code NNNN=Number XXXXXXXX=Extension CEDI Help Desk Phone Number: 866-311-9184

The Response Claim Segment is **not used** when there are only Transmission Level errors.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 31. Claim Billing Rejected Response – Response Claim Segment (S)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
111-AM	Segment Identification	22	M	Response Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	Only value '1' is allowed for Claim Billing (B1) transactions. 1 – Rx Billing
402-D2	Prescription/Service Reference Number	Same value as in request	M	**Note:** Leading zeros will be truncated on response.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 32. Claim Billing Rejected Response – Batch Trailer Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	99	M	None
806-5C	Batch Number	[Batch Number]	M	Batch Number from original inbound batch header field 806-5C
751	Record Count	[Count]	M	Calculated number of records in batch (i.e. G1 data detail records plus header and trailer).

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
504-F4	Message	[Spaces]	M	Space filled to maximum positions.

9.4 Claim Billing Batch Rejected Response

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 33. Claim Billing Batch Rejected Response – Batch Header Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	00	M	None
880-K6	Transmission Type	E	M	None
880-K1	Trading Partner ID (Submitter ID)	16013, 17013, 18003, 19003	M	DME MAC contractor ID number from original inbound batch header field 880-K7.
806-5C	Batch Number	[Batch Number]	M	Batch Number from original inbound batch header field 806-5C.
880-K2	Creation Date	[Date]	M	Format = CCYYMMDD CC – Century YY – Year MM – Month DD – Day
880-K3	Creation Time	[Time]	M	Format = HHMM HH = Hour MM = Minute
702	File Type	P or T	M	P = Production T = Test From the original inbound batch header field 702.
102-A2	Version/Release Number	12	M	The batch version number from original inbound batch header field 102-A2.
880-K7	Receiver ID	CEDI assigned Trading Partner ID	M	Receiver ID (Trading Partner ID) from original inbound batch header field 880-K1.

Note: Any values in the Value column in brackets describes the type of value sent. The Medicare Note column will have the data entered in the field.

Table 34. Claim Billing Batch Rejected Response – Batch Trailer Record (M)

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
701	Segment Identification	99	M	None
806-5C	Batch Number	[Batch Number]	M	Batch Number from original inbound batch header field 806-5C.
751	Record Count	[Count]	M	Calculated number of records in batch (i.e. G1 data detail records plus header and trailer).
504-F4	Message	1-xxxxxxxxxx 2-xxxxxxxx	M	Free form error message. Preceded by number and hyphen to denote beginning and end of each message.

10 Frequently Asked Questions

1. What is NCPDP?

   The National Council for Prescription Drug Programs (NCPDP) is the format used by retail pharmacies to electronically submit DME MAC drug claims. The NCPDP format can only be used for drug claims from retail pharmacies.

2. What reports can I expect for NCPDP D.0 claims submitted to CEDI?

   CEDI will return the following reports:

   - CEDI TRN Acknowledgement Report
   - CEDI NCPDP Transmission Response

   Note: The CEDI reports are returned in real time and are typically delivered to the Trading Partner within 30 minutes. However, the size of the claim files will determine how long it takes to produce the reports.

3. Where can I get more information about the NCPDP front-end edits?

   NCPDP error codes can be found in the CEDI NCPDP D.0 Front End Edits manual located on the CEDI website (https://cedi.wellpointfederal.com) under Front End Edits & Reports.

11 Acronyms

Table 35. Acronyms

Acronym	Definition
276	276 Claim Status Request transaction
277	277 Claim Status Response transaction
277CA	277 Claim Acknowledgement
835	835 Electronic Remittance Advice transaction
837P	837 Professional Claims transaction
999	Implementation Acknowledgment
ASC	Accredited Standards Committee
CCI	Communications/Connectivity Information
CCN	Claim Control Number
CEDI	Common Electronic Data Interchange
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
DME	Durable Medical Equipment
ECL	External Code List
EDI	Electronic Data Interchange
EPO	Epoetin
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HTTP	Hyper Text Transfer Protocol
HTTPS	Hyper Text Transfer Protocol Secure
IG	Implementation Guide

Acronym	Definition
IVR	Integrated Voice Response
MAC	Medicare Administrative Contractor
MIME	Multipurpose Internet Mail Extensions
MSP	Medicare Secondary Payer
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPEAST	National Provider Enrollment Eastern Region
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
NPWEST	National Provider Enrollment Western Region
NSV	Network Service Vendor
PECOS	Provider Enrollment, Chain and Ownership System
PHI	Protected Health Information
PID	Packet Identifier
PTAN	Provider Transaction Access Number
sFTP	Secure File Transfer Protocol
SNOMED CT®	Systematized Nomenclature of Medicine Clinical Terms®
SOAP	Simple Object Access Protocol
TPA	Trading Partner Agreement
TRN	Transaction Acknowledgement report (CEDI proprietary report)
WSDL	Web Services Description Language
X12	A standards development organization that develops EDI standards and related documents for national and global markets (See the official ASC X12 website.)
X12N	Insurance subcommittee of X12

13 CCI Change Summary

Table 36. Change Summary

Date	Revision Number	Description of Change	Author
01-21-2011	V1.0	Original Draft	NGS CEDI
02-08-2011	V 1.1	Updated verbiage in Section 1.1 Scope	NGS CEDI
02-23-2011	V 1.2	Updated NHIC, Inc. to NHIC, Corp. Table formatting changes	NGS CEDI
06-13-2011	V 1.3	Updated CIGNA Government Services to CGS Administrators LLC	NGS CEDI
01-29-2016	V 1.4	Updated enrollment information, flow charts, CEDI e-mail address and CEDI Web site links	NGS CEDI
06-24-2016	V 1.5	Updated Jurisdiction transition information related to Jurisdiction A and B	NGS CEDI
05-08-2020	V 1.6	Updated/verified the URLs in all sections	NGS CEDI
September 2021	V 1.7	Section 4.1 – updated transaction flow diagrams Section 5.2 – reordered states under Jurisdiction B in alphabetical order; added MP state code under Jurisdiction D Section 9.1 – replaced references to HICN with MBI Verified hyperlinks and updated as needed throughout the document	NGS CEDI
March 2022	V 1.8	508 compliance and table formatting.	NGS CEDI

Date	Revision Number	Description of Change	Author
December 2022	V 1.9	Replaced “ANSI” with “ASC” throughout document Section 4.1, Figure 1 – updated process flow Section 4.3 – replaced with verbiage to match X12 Companion Guides Section 4.4 – added first three paragraphs to match X12 Companion Guides Section 5.2 – added contact information for NPEAST, NPWEST, NPPES and PECOS to match X12 Companion Guides Section 8.2 – spelled out acronyms for End Stage Renal Disease and Epoetin Section 11 – added new section for Acronyms	NGS CEDI
January 2025	V 1.10	Section 4.1, Figure 1 – updated process flow Section 8.2, General Requirements #11 – removed reference to CMN Section 11, Table 35 – updated Acronyms to remove “CMN”	NGS CEDI
October 2026	V 1.11	Changed National Government Services and NGS to Wellpoint Federal throughout Updated CEDI URLs for the Wellpoint Federal change Updated CEDI Help Desk email address Section 2.3 – updated to reflect retail pharmacy claims can be submitted in the 837P or NCPDP Section 2.3, list item 8 – added timeframe for CEDI to return test results Section 3 – updated to reflect retail pharmacies may use the NCPDP format Section 4.3 – added “P” to 837 Section 4.4, Guidelines for passwords - moved password expire every 60 days to before the list of Do’s and Don’ts Section 5.1 – updated CEDI Help Desk hours of operation; added	Wellpoint Federal CEDI