Effective: 02/14/2011

Oklahoma *SoonerCare*

NCPDP D.0 Transactions Payer Sheets

NCPDP Version D.0 defines the data structure and content of single POS transmissions only.

These specifications cover the minimum required fields per the NCPDP D.0 standards as well as the required fields needed for Oklahoma Medicaid claims processing. Even though a segment or field may not be covered in this document, it does not mean the segment or field cannot be sent. All records, segments, and fields that are allowed for NCPDP D.0 will be accepted, but only those segments and fields pertinent to claims processing will be utilized in the Oklahoma Medicaid claims system. However, please be cognizant of the size of the transmission and possible problems with processing time on transmissions containing elements that will be ignored by Oklahoma Medicaid.

Please refer to the NCPDP Telecommunication Standard Implementation Guide Version D Release 0 for further information on the various segments and fields allowed.

Please refer to the External Code List (ECL) version dated April 2011 to obtain code values for data elements contained within the NCPDP standards.

CHANGE Log

Date	Changed By	CO/Ticket/Ref Number	Description of Changes
1/30/2017	Jill A. Linderman	CO20132	Added 506-F6, 566-J5 and 522-FM to the AM23 Response segment
3/30/2020	Jill A. Linderman	CO22729	Added 420-DK in support of COVID-19

			Early Refill Override
3/30/2020	Leilei Wang	CO22644	Added 460-ET to claim segment
1/13/2021	Jill A. Linderman	CO23337	Add info for 354-NX and420-DX Usage.
7/7/2021	Jill A. Linderman	CO23782	Add 307-C7, Place of Service to the Patient Segment
9/20/2021	Jill A. Linderman	CO23956	Added submission clarification code value of 7 – Medically Necessary as one of the codes currently used in processing.
02/22/2022	Jill A. Linderman	CO24293	Add submission clarification code value of 10 – Meets Plan Limitations (should have been added under 23956). Added 01 – Pharmacy as value used within claims for Place of Service (307-C7).

NCPDP vD.0 Transaction Set Information

General Transaction Formatting Information:
The first segment of every transmission (request or response) is the Header Segment. This is the only segment that does not have a Segment Identification since it is a fixed field and length segment. After the Header Segment, other segments are included, according to the particular transaction type. Every other segment has an identifier to denote the particular segment for parsing. Segments may appear in any order after the Header Segment, according to whether the segment occurs at the transmission or transaction level. Segments are not allowed to repeat within a transaction. Segments may occur more than once only in a multi-transaction transmission.

In the Header Segment, all fields are required positionally and filled to their maximum designation. This is a fixed segment. If a required field is not used, it must be filled with spaces or zeroes, as appropriate. The fields within the Header Segment do not use field separators.

Other segments may have both required and optional fields. Optional fields in a segment are submitted after the required fields. Both types of fields must be preceded by a field separator and the field's identifier. Optional fields may appear in any order except for those designated with a qualifier or in a repeating group. The required and optional fields may be truncated to the actual size used.

Parsing is accomplished with the use of separators. Version D.0 uses three separators.

- Segment separator Hex 1E (Dec 3Ø)

- Group separator Hex 1D (Dec 29)
- Field separator Hex 1C (Dec 28)

A transmission consists of one or more transactions separated by group separators. All transmissions, whether for one, two, three, or four transactions, use group separators to denote the start of a transaction.

Within a transaction, appropriate segments are included. Segments are delineated with the usage of Segment separators. Segments are also identified with the usage of a Segment Identification in the first position of each segment. One to many segments may be included in each transaction. Field separators are used to delineate fields in the segments.

The general syntax of a transmission request and response will appear as follows:

| Header Segment
| Header Segment Fields
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators
Group Separator
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators
Segment Separator
Required Fields within Segment as appropriate, with field separators
Optional Segment Fields with field separators

Variable Usage Guidelines:

- Version D.0 allows variable length transactions only.
- Version D.0 supports up to four transactions per transmission for transaction codes B1 and B2. Compound billing transactions (B1) may only contain one transaction.
- Leading zeros and trailing blanks may be omitted from some data fields.
- Alphanumeric fields default to spaces, not null characters, when empty.
- Numeric fields default to zeroes
- Dollar fields default to zeroes; however, dollar fields are always signed. The least significant digit of a dollar field must always be an Overpunch Sign, not a digit.

The Overpunch Sign:

The purpose of using Overpunch signs in dollar fields is to allow the representation of positive and negative dollar amounts without expanding the size of the field (i.e., to hold the plus or minus character).

The Overpunch sign replaces the right most character in a dollar field. The signed value designates the positive or negative status of the numeric value. The dollar field of $99.95 would be represented as 999E with truncation. A negative dollar amount of $2.5Ø would be represented as 25} with truncation.

UNIT	SIGNED POSITIVE GRAPHI	OCT	DEC r	HEX	SIGNED NEGATIVE GRAPHI	OCT	DEC c	HEX
0	{	173	123	7B	}	175	125	7D
1	A	1Ø1	65	41	J	112	74	4A
2	B	1Ø2	66	42	K	113	75	4B
3	C	1Ø3	67	43	L	114	76	4C
4	D	1Ø4	68	44	M	115	77	4D
5	E	1Ø5	69	45	N	116	78	4E
6	F	1Ø6	7Ø	46	O	117	79	4F
7	G	1Ø7	71	47	P	12Ø	8Ø	5Ø
8	H	11Ø	72	48	Q	121	81	51
9	I	111	73	49	R	122	82	52

Table shows ASCII values

Implied Decimal Points:
In the D.0 standard, only patient clinical value fields will contain decimal points. All other decimal points are implied. For example, patient diagnosis codes should be formatted with explicit decimal points. NOTE: Decimal points in dollar fields are implied.

Truncation:
To truncate a field using D.0 format:

NUMERIC (N or D)	Remove leading zeros
ALPHANUMERIC (A)	Remove trailing spaces

Do not truncate or eliminate any fields in the required header segments.

NCPDP vD.0 Transaction Set Specifications

Following is a list of the data elements, field names, and field positions for the Oklahoma Interchange Pharmacy System (OKIPS) claims using the NCPDP version D.0 format.

Standard COBOL documentation is used for transaction descriptions. The following definitions are given to ensure consistency of interpretation:

- **Field** - The NCPDP vD.0 data element identifier for a given transaction.
- **Field Name** - The short definition, name, or literal constant of the data located within the transaction at the positions indicated.
- **Picture (Pic)** - The COBOL "PICTURE" clause that describes how the data is presented on the transmission.
  X = An alphanumeric character
  9 = A numeric character

S = A numeric value sign (+ or -) V = An implied decimal point
() = The character if front of the left parenthesis is repeated the number of times between the parentheses; i.e., X(5) represents the same PICTURE as XXXXX.

- **Type** - The type of data in the field.

  A - Alpha/Numeric - Always left-justified and space filled; A-Z, Ø-9, and printable characters.
  D - Signed Numeric - Always right-justified, zero always positive, zero filled dollar-cents amount with 2 positions to the right of the implied decimal point, all other positions to the left of the implied decimal point, and have default values of zeros when used for dollar fields. (Sign is internal and trailing)
  Example: D field of length 8 is represented $$$$$$cc
  N - Unsigned Numeric - Always right-justified and zero filled.
  Example: 9(7) V999 is represented as 9999999.999

- **Value** - If a particular value is expected for the Oklahoma Interchange Pharmacy System (OKIPS), that value is given.

- **Comments - NCPDP vD.0** is a **variable length format** standard. Therefore, with the exception of the header fields (which are always required), a transaction will contain only those elements that are necessary. The "Comment" portion indicates whether or not a field is Mandatory, Required or Required When. Fields marked as "Mandatory" are defined as mandatory by the NCPDP Telecommunication Implementation Guide Version D.0. Fields marked as "Required" are defined as required by the processor (HP). Fields marked as "Required When" are truly optional, but are Required When the data is known by the submitter.

VAN/Switch Header Formats

All input transactions submitted by telecommunications network switches to the Oklahoma Interchange Pharmacy System (OKIPS) must be in the following envelope. A 16-byte header must be prefixed to each OKIPS transaction submitted to the Oklahoma Interchange Pharmacy System by any network switch. The format of the header is as follows:

- Bytes 1-3. Must be a network switch identifier. If an ID was previously assigned to a network switch for the Rx-POS system, it is not necessary to obtain an additional identifier for the Oklahoma Interchange Pharmacy System (OKIPS). Network IDs assigned for the Rx-POS system will be accepted for the Oklahoma Interchange Pharmacy System.

- Bytes 4-9. Should contain an identifier containing any combination of the characters 0-9, A-Z, or a-z, or they should contain all zeroes. The switch uses this to match up the response

with the original request. This is necessary since many claims are processed in parallel, and the response to a later claim may be returned before the response to an earlier claim. If a switch does not use this identifier, it will have to single thread the claims sent to HP; i.e., send one claim and wait for the response before sending another.

- Bytes 10-16. Must be spaces.

Each POS transaction submitted to the Oklahoma Interchange Pharmacy System (OKIPS) by any network must be terminated by an "End of Transaction" (EOT) flag consisting of a single (1) byte containing the binary value 00000100, which is equal to 04 in Octal, Decimal, or Hexadecimal. Response transactions returned to the network by the Oklahoma Interchange Pharmacy System (OKIPS) will be in the following envelope:

- The same header that was prefixed to the input transaction by the telecommunications network switch will be prefixed to the response transaction returned to the network switch (with some variations depending on the requirements of the switch).
- The response transaction will be terminated with an EOT in the same way as the input transaction.

VERSION D.0 SUBMISSIONS

Claim Request

Transaction Header Segment: Mandatory (in all cases)

Field	Field Name	Pic	Type	Value	Comments
101-A1	Bin Number	9(6)	N	'010579'-*SoonerCare*	Mandatory
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'B1'-RX Billing	Mandatory
104-A4	Processor Control Number	X(10)	A	1-5 ***'OKA01'*** Production ***'OKAT1'*** Test 6-8 Network System ID	Mandatory
109-A9	Transaction Count	X(1)	A	'1' - One Occurrence '2' - Two Occurrences '3' - Three Occurrences '4' - Four Occurrences **Max of 1 allowed for compound transactions.**	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'-National Provider Identifier (NPI)	Mandatory

201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-D1	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory
110-AK	Software Vendor/Certification ID	X(10)	A	Spaces	Mandatory

Insurance Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'04' - Insurance	Mandatory
302-C2	Cardholder ID	X(20)	A	Cardholder ID Number (Client ID Number) Oklahoma: Nine (9) digit Member ***SoonerCare*** ID number	Mandatory
312-CC	Cardholder First Name	X(12)	A	The cardholder's first name	Required
313-CD	Cardholder Last Name	X(15)	A	The cardholder's last name	Required

Insurance Segment *(Cont'd)*

Field	Field Name	Pic	Type	Value	Comments
301-C1	Group ID	X(15)	A	Pay To Pharmacy 10-digit National Provider Identifier (NPI) **Not needed if same as servicing provider field 201-B1**	Required **(For HMO use only)**

Patient Segment: Optional (Segment only present if 335-2C is populated)

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'01'-Patient	Mandatory
335-2C	Pregnancy Indicator	X(1)	A	'1'-Not Pregnant '2'-Pregnant	Required When
3Ø4-C4	DATE OF BIRTH	9(8)	N	Format=CCYYMMDD	Required.
3Ø5-C5	PATIENT GENDER CODE	9(1)	N	0=Not Specified 1=Male 2=Female	Required.
31Ø-CA	PATIENT FIRST NAME	X(12)	A	Patient's First Name	Required when the patient has a first name.
311-CB	PATIENT LAST NAME	X(15)	A	Patient's Last Name	Required.
307-C7	PLACE OF SERVICE	9(2)	N	Following are the only values currently used in processing/pricing of a pharmacy claim. 01 - Pharmacy 12 – Home	Required When

Claim Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'07'-Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	X(1)	A	'1'-Rx Billing	Mandatory
402-D2	Prescription/Service Reference Number	9(12)	N	Prescription Number	Mandatory
436-E1	Product//Service ID Qualifier	X(2)	A	'03'-NDC If billing for a multi-ingredient prescription, Product/Service ID Qualifier (436-E1) is zero ("ØØ").	Mandatory
407-D7	Product/Service ID	X(19)	A	NDC (Drug Code) Oklahoma: 11 characters If billing for a multi-ingredient prescription, Product/Service ID (4Ø7-D7) is zero.	Mandatory

442-E7	Quantity Dispensed	9(7)V999	N	Oklahoma: Maximum of 9(7)V999 allowed. Format=9999999.999	Required
460-ET	Quantity Prescribed	9(7)V999	N	Oklahoma: Maximum of 9(7)V999 allowed. Format=9999999.999	Required if billing CII Drug
403-D3	Fill Number	9(2)	N	'00' - New (Original Dispensing) '01' - '99' - Refill Number	Required
405-D5	Days Supplied	9(3)	N	Estimated number of days the prescription will last	Required
406-D6	Compound Code	9(1)	N	'1' - Not a Compound '2' -Compound	Required
419-DJ	Prescription Origin Code	9(1)	N	'0' – Not Specified '1' – Written '2' – Telephone '3' – Electronic '4' – Facsimile '5' - Pharmacy	Required
354-NX	Submission Clarification Code Count	9(2)	N	Oklahoma: Max of 3 allowed/processed.	Required if Submission Clarification Code (42Ø-DK) is used.
420-DK	Submission Clarification Code	9(2)	N	Oklahoma: Max of 3 allowed/used. Following values currently used in processing. 2 - Other Override (1st Dose) 6 - Starter dose. (2nd Dose) The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment. 10 – Meets Plan Limitations (Booster Dose). 13 - Payer-Recognized Emergency/Disaster Assistance Request - The pharmacist is indicating that an override is needed based on an emergency/disaster	Required if clarification is needed and value submitted is greater than zero (Ø).

				situation recognized by the payer. 42 - Prescriber ID Submitted is valid and prescribing requirements have been validated. Used by payers to override prescriber NPI validation rules Other values submitted will not be processed by Oklahoma.	

Claim Segment *(Cont'd)*

Field	Field Name	Pic	Type	Value	Comments
408-D8	Dispensed As Written (DAW)	X(1)	A	'0'-No DAW '1'-Physician DAW '2'-Patient DAW '3'-Pharmacy DAW '4' -No Generic Available '5' - Brand Dispensed as Generic '6' – Override '7' - Law Mandates Brand Drug '8'-Sub Allowed -Generic Unavailable '9'- Patient's Plan Mandates Brand Drug	Required When
414-DE	Date Prescription Written	9(8)	N	Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Required
308-C8	Other Coverage Code	9(2)	N	'0'-Not Specified '1' - No other coverage identified '2' - Other coverage exists-payment collected '3' - Other coverage exists-this claim not covered '4' - Other coverage exists-payment not collected	Required

418-DI	Level of Service	9(2)	N	'00'-Not Specified '01' - Patient Consultation '02'-Home Delivery '03' -Emergency '04'-24 Hour Service '05' - Patient Consultation Regarding Generic Product Selection '06' - In-Home Service	Required When
462-EV	Prior Authorization Number Submitted	9(11)	N	Prior Authorization Number	Required When
147-U7	PHARMACY SERVICE TYPE	9(2)		1=Community/Retail Pharmacy Services 2=Compounding Pharmacy Services 3=Home Infusion Therapy Provider Services 4=Institutional Pharmacy Services 5=Long Term Care Pharmacy Services 6=Mail Order Pharmacy Services 7=Managed Care Organization Pharmacy Services 8=Specialty Care Pharmacy Services	Required

Prescriber Segment: Required

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'03'-Prescriber	Mandatory
466-EZ	Prescriber Identification Qualifier	X(2)	A	'01' - National Provider Identifier (NPI)	Required
411-DB	Prescriber Identification	X(15)	A	Individual Prescriber 10-digit National Provider Identifier (NPI)	Required
427-DR	Prescriber Last Name	X(15)	A	Prescriber Physician's Last Name	Required
364-2J	Prescriber First Name	X(12)	A	Prescriber Physician's First Name	Optional

COB / Other Payments Segment: Optional

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'05'-COB/Other Payer	Mandatory

337-4C	Coordination of benefits/ other payments count	9(1)	N	Max of 9 allowed	Mandatory
338-5C	Other Payor Coverage Type	X(2)	A	Oklahoma = '01'	Mandatory
341-HB	Other Payer Amount Paid Count	9(1)	N	Max of 9 allowed	Required When
342-HC	Other Payer Amount Paid Qualifier	X(2)	A	Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound Preparation Cost 1Ø=Sales Tax	Required When
431-DV	Other Payer Amount Paid	S9(6)V99	D	Format is $$$$$$cc.	Required When
471-5E	Other Payer Reject Count	9(2)	N	Oklahoma: Max of 9 allowed	Required When
472-6E	Other Payer Reject Code	X(3)	A	The NCPDP Reject Code(s) encountered by the previous "Other Payer".	Required When (Repeating)
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	9(2)	N	Maximum count of 25.	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.

351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	X(2)	A	00=Blank Not Specified 01=Amount Applied to Periodic Deductible (517-FH). 02=Amount Attributed to Product Selection/Brand Drug (134-UK). 03=Amount Attributed to Sales Tax (523-FN). 04=Amount Exceeding Periodic Benefit Maximum (520-FK). 05= Amount of Copay (518-FI). 06=Patient Pay Amount (505-F5). 07=Amount of Coinsurance (572-4U). 08=Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM). 09=Amount Attributed to Health Plan Assistance Amount (129-U D).	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	s9(8)v99	D	The patient's cost share from a previous payer Format is $$$$$$cc.	Required

DUR / PPS Segment: Optional

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'08' -DUR/PPS	Mandatory
473-7E	DUR/PPS Code Counter	9(1)	N	Oklahoma = '1' Max of 1 allowed	Required When

439-E4	Reason for Service Code	X(2)	A	Oklahoma: DD=Drug-Drug Interaction ER=Overuse (early refill) HD=High Dose ID=Ingredient Duplication LD=Low Dose LR=Underuse (late refill) MX=Excessive Duration PG=Drug-Pregnancy TD=Therapeutic Duplication MN=Minimum Duration PA=Drug Age MC=Drug Disease	Required When
440-E5	Professional Service Code	X(2)	A	M0=Prescriber Consulted P0=Patient Consulted R0=Pharmacist Consulted Other Source	Required When
441-E6	Result of Service Code	X(2)	**A**	1A=Filled As Is, False Positive 1B=Filled Prescription As Is 1C=Filled, With Different Dose 1D=Filled, With Different Directions 1E=Filled, With Different Drug 1F=Filled, With Different Quantity 1G=Filled, With Prescriber Approval 2A=Prescription Not Filled 2B=Not Filled, Directions Clarified	Required When

Pricing Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'11'-Pricing	Mandatory
4Ø9-D9	INGREDIENT COST SUBMITTED	s9(6)v99	D	Submitted product component cost of the dispensed prescription. Included in the Gross Amount Due. Format is $$$$$$cc	Required.
426-DQ	Usual and Customary Charge	S9(6)V99	D	Format is $$$$$$cc	Required
43Ø-DU	GROSS AMOUNT DUE	s9(6)v99	D	Total price claimed from all sources.	Required. See Pricing Formula for fields used in calculation.
423-DN	BASIS OF COST DETERMINATION	X(2)	A	00=Default 08=34ØB/Disproportionate Share Pricing/Public Health Service -The 34ØB Drug Pricing Program from the Public Health Service Act, sometimes referred to as "PHS Pricing" or "6Ø2 Pricing" is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price	Required

Compound Segment: Optional

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'10' -Compound **Field 406-D6 in the claim segment must be = '2'**	Mandatory

450-EF	Compound Dosage Form Description Code	X(2)	A	Accepted Values for D.0 listed below	Mandatory
451-EG	Compound Dispensing Unit Form Indicator	9(1)	N	'1'-Each '2' – Grams '3'-Millimeters	Mandatory
447-EC	Compound Ingredient Component Count	9(2)	N	Oklahoma: 1-25 Max of 25 allowed	Mandatory
488-RE	Compound Product ID Qualifier	X(2)	A	'03'-NDC	Mandatory (Repeating)
489-TE	Compound Product ID	X(19)	A	NDC (Drug Code)	Mandatory (Repeating)
448-ED	Compound Ingredient Quantity	9(7)V999	N	Oklahoma: Maximum of 9(6)V999 allowed.	Mandatory (Repeating)

Clinical Segment: Optional

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'13'-Clinical	Mandatory
491-VE	Diagnosis Code Count	9(1)	N	Oklahoma-'01' Max of 1 allowed	Required When
492-WE	Diagnosis code Qualifier	X(2)	A	Oklahoma: '01'-International Classification of Diseases Clinical Modification code.	Required When
424-DO	Diagnosis Code	X(15)	A	Applicable International Classification of Diseases Clinical Modification code.	Required When

Claim Reversal

Transaction Header Segment: Mandatory (in all cases)

Field	Field Name	Pic	Type	Value	Comments
101-A1	Bin Number	9(6)	N	'010579'-**OK *SoonerCare***	Mandatory
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'B2' Reversal	Mandatory

104-A4	Processor Control Number	X(10)	A	1-5 ***'OKAO1'*** Production ***'OKAT1'*** Test 6-8 Network System ID	Mandatory
109-A9	Transaction Count	X(1)	A	'1' - One Occurrence '2' - Two Occurrences '3' - Three Occurrences '4' - Four Occurrences	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-D1	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory
110-AK	Software Vendor/Certification ID	X(10)	A	Spaces	Mandatory

Claim Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'07' Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	X(1)	A	'1'-Rx Billing	Mandatory
402-D2	Prescription/Service Reference Number	9(12)	N	Prescription Number	Mandatory
436-E1	Product/Service ID Qualifier	X(2)	A	'00'-Not Specified '03'-NDC	Mandatory
407-D7	Product/Service ID	X(19)	A	Spaces or Applicable NDC	Mandatory

Eligibility Request

Transaction Header Segment: Required (in all cases)

Field	Field Name	Pic	Type	Value	Comments
101-A1	Bin Number	9(6)	N	'010579'-**OK *SoonerCare***	Mandatory
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'E1' Eligibility Verification	Mandatory
104-A4	Processor Control Number	X(10)	A	1-5 ***'OKA01'*** Production ***'OKAT1'*** Test 6-8 Network System ID	Mandatory
109-A9	Transaction Count	X(1)	A	' 1' - One Occurrence	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-D1	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory
110-AK	Software Vendor/Certification ID	X(10)	A	Spaces	Mandatory

Patient Segment: Optional

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'01'Patient	Mandatory
304-C4	Date of Birth	9(8)	N	'CCYYMMDD' CC - Century YY-Year MM – Month DD – Day	Required when

Patient Segment: Optional (Cont'd)

Field	Field Name	Pic	Type	Value	Comments
305-C5	Patient Gender Code	9(1)	**N**	'Ø'-Not Specified '1'-Male '2'-Female	Required when

Insurance Segment: Required

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	**A**	'04' - Insurance Segment	Mandatory
302-C2	Cardholder ID	X(20)	**A**	Cardholder ID Number (Client ID Number) Oklahoma: Nine (9) digit Member ***SoonerCare*** ID number	Mandatory

VERSION D.0 RESPONSES

Billing Paid Response

Response Header Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	'D0' –Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'B1'-Billing	Mandatory
109-A9	Transaction Count	X(1)	A	'1' - One Occurrence '2' - Two Occurrences '3' - Three Occurrences '4' - Four Occurrences	Mandatory
501-F1	Header Response Status	X(1)	A	'A' - Accepted	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-D1	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory

Response Message Segment: Required

Field	Field Name	Pic	Type	Value	Comments

111-AM	Segment Identification	X(2)	A	'20' - Response Message Segment	Mandatory
504-F4	Message	X(200)	A	This field will contain response specific text.	Required

Response Status Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'21'-Response Status Segment	Mandatory
112-AN	Transaction Response Status	X(1)	A	'P'-Paid	Mandatory
503-F3	Authorization Number	X(20)	A	13 character Internal Control Number (ICN) for Original Claim	Required
130-UF	Additional Message Information Count	9(2)	N	Maximum count of 25. Currently limited to 9 due to current valid values for 132-UHf.	Required if 526-FQ is sent.
132-UH	Additional Message Information Qualifier	X(2)	A	01=first line 02=second line 03=third line 04=fourth line 05=fifth line 06=sixth line 07=seventh line 08=eighth line 09=ninth line	Required if 526-FQ is sent.
526-FQ	Additional Message Information	X(40)	A	Additional message if needed.	Required When

131-UG	Additional Message Information Continuity	X(1)	A	'*'=message continues	Required if and only if current repetition of Additional Message Informatio n (526-FQ) is used, another populated repetition of Additional Message Informatio n (526-FQ) follows it, and the text of the following message is a cont-inuaton of the current.

Response Claim Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'22' - Response Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	X(1)	A	'1'-Rx Billing	Mandatory
402-D2	Prescription/Service Reference Number	X(12)	A	Prescription Number	Mandatory

Response Pricing Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments

<table>
<tr><td>111-AM</td><td>Segment Identification</td><td>X(2)</td><td>A</td><td>'23' - Response Pricing</td><td>Mandatory</td></tr>
<tr><td>505-F5</td><td>Patient Pay Amount</td><td>S9(6)V99</td><td>D</td><td>Format s$$$$$cc</td><td>Required</td></tr>
<tr><td>507-F7</td><td>Dispensing Fee Paid</td><td>S9(6)V99</td><td>D</td><td>Format s$$$$$cc</td><td>Required</td></tr>
<tr><td>509-F9</td><td>Total Amount Paid</td><td>S9(6)V99</td><td>D</td><td>Format s$$$$$cc</td><td>Required</td></tr>
<tr><td>518-FI</td><td>Amount of Copay/Coinsurance</td><td>S9(6)V99</td><td>D</td><td>Format s$$$$$cc</td><td>Required</td></tr>
<tr><td>506-F6</td><td>Ingredient Cost Paid</td><td>S9(6)V99</td><td>D</td><td>Format s$$$$$cc</td><td>Required – Total ingredient cost paid prior to copay, TPL and Dispense Fee.</td></tr>
<tr><td>566-J5</td><td>Other Payer Amount Recognized</td><td>S9(6)V99</td><td>D</td><td>Format s$$$$$cc</td><td>Required When</td></tr>
<tr><td>522-FM</td><td>Basis of Reimbursement Determination</td><td>9(2)</td><td>N</td><td>Not applicable to Compound Drug Claims. Pricing scenario other than those listed below will result in a zero value returned.

<table><tr><th>Pricing Scenario</th><th>Value Used</th></tr><tr><td>EAC or EACW Pricing (pricing indicator of E)</td><td>3</td></tr><tr><td>Provider billed less than calculated price (allowed amount was cutback to billed amount)</td><td>5</td></tr><tr><td>SMAC Pricing (pricing indicator of H)</td><td>7</td></tr><tr><td>SPAC Pricing (pricing indicator of Z)</td><td>10</td></tr><tr><td>WAC Pricing (pricing indicator of W)</td><td>13</td></tr><tr><td>Allowed amount cutback due to TPL amount</td><td>14</td></tr><tr><td>NADACB or NADACG Pricing (pricing indicator of B or G)</td><td>20</td></tr></table></td><td>Required for non-compound drug claims.</td></tr>
</table>

Response DUR/PPS Segment: Optional (Only required if DUR info is sent in response)

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'24' - Response DUR/PPS	Mandatory
567-J6	DUR/PPS Response Code Counter	9(1)	N	Counter number for each DUR/PPS response set / logical grouping.	Required When
439-E4	Reason for Service Code	X(2)	A	Accepted D.0 Values are listed below	Required When
528-FS	Clinical Significance Code	X(1)	A	Blank - Not Specified '1'-Major '2'-Moderate '3'-Minor	Required When
529-FT	Other Pharmacy Indicator	9(1)	N	'0'-Not Specified '1' - Your Pharmacy '3'-Other Pharmacy	Required When
530-FU	Previous Date of Fill	9(8)	N	Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Required When
531-FV	Quantity of Previous Fill	9(7)V999	N	Oklahoma: Maximum of 9(7)V999 allowed. Format=9999999.999	Required When
532-FW	Database Indicator	X(1)	A	Blank - Not Specified '1'-First Data Bank	Required When
533-FX	Other Prescriber Indicator	9(1)	N	'0'-Not Specified '1' - Same Prescriber '2'-Other Prescriber	Required When
544-FY	DUR Free Text Message	X(30)	A	Additional DUR message if needed.	Required When
570-NS	DUR Additional Text	X(100)	A	Information to further define the DUR event.	Required When

Billing Reject Response

Response Header Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'B1'Billing	Mandatory
109-A9	Transaction Count	X(1)	A	'1' - One Occurrence '2' - Two Occurrences '3' - Three Occurrences '4' - Four Occurrences	Mandatory
501-F1	Header Response Status	X(1)	A	'A' - Accepted	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-Dl	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory

Response Message Segment: Required

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'20' Response Message	Mandatory
504-F4	Message	X(200)	A	Additional transaction specific messages.	Required

Response Status Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'21'- Response Status	Mandatory
112-AN	Transaction Response Status	X(1)	A	'R' - Rejected	Mandatory
503-F3	Authorization Number	X(20)	A	13 character Internal Control Number (ICN)	Required
510-FA	Reject Count	9(2)	N	Max count of 5 per D.0.	Required
511-FB	Reject Code	X(3)	A	NCPDP Reject Code	Required

130-UF	Additional Message Information Count	9(2)	N	Maximum count of 25. Currently limited to 9 due to current valid values for 132-UH.	Required if 526-FQ is sent.
132-UH	Additional Message Information Qualifier	X(2)	A	01=first line 02=second line 03=third line 04=fourth line 05=fifth line 06=sixth line 07=seventh line 08=eighth line 09=ninth line	Required if 526-FQ is sent.
526-FQ	Additional Message Information	X(40)	A	Additional message if needed. Other Carrier Name and Address if applicable (COB/TPL info). ***SoonerCare HMO name and phone # if client is assigned to a Medicaid HMO.***	Required When

131-UG	Additional Message Information Continuity	X(1)	A	'*'=message continues	Required if and only if current repetition of Additional Message Informatio n (526-FQ) is used, another populated repetition of Additional Message Informatio n (526-FQ) follows it, and the text of the following message is a cont-inuaton of the current.
987-MA	URL	X(255)	A		Provided for informational purposes only to relay health care communic ations via the Internet.

Response Claim Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'22' - Response Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	X(1)	A	'1'-Rx Billing	Mandatory

402-D2	Prescription/Service Reference Number	9(12)	N	Prescription Number	Mandatory

Response DUR/PPS Segment: Optional (Only required if DUR info is sent in response)

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'24' - Response DUR/PPS	Mandatory
567-J6	DUR/PPS Response Code Counter	9(1)	N	Counter number for each DUR/PPS response set / logical grouping.	Required When
439-E4	Reason for Service Code	X(2)	A	Accepted D.0 Values are listed below	Required When
528-FS	Clinical Significance Code	X(1)	A	Blank-Not Specified '1'-Major '2'-Moderate '3'-Minor	Required When
529-FT	Other Pharmacy Indicator	9(1)	N	'0'-Not Specified '1' - Your Pharmacy '3'-Other Pharmacy	Required When
530-FU	Previous Date of Fill	9(8)	N	Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Required When
531-FV	Quantity of Previous Fill	9(7)V999	N	Oklahoma: Maximum of 9(7)V999 allowed. Format=9999999.999	Required When
532-FW	Database Indicator	X(1)	A	Blank-Not Specified '1'-First Data Bank '2'-Medi-Span '3'-Redbook '4' - Processor Developed '5'-Other	Required When
533-FX	Other Prescriber Indicator	9(1)	N	'0'-Not Specified '1' - Same Prescriber '2'-Other Prescriber	Required When
544-FY	DUR Free Text Message	X(30)	A	Additional DUR message if needed.	Required When
570-NS	DUR Additional Text	X(100)	A	Information to further define the DUR event.	Required When

Reversal Approved Response

Response Header Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'B2'Reversal	Mandatory
109-A9	Transaction Count	X(1)	A	'1' - One Occurrence '2' - Two Occurrences '3' - Three Occurrences '4' - Four Occurrences	Mandatory
501-F1	Header Response Status	X(1)	A	'A' - Accepted	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-Dl	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory

Response Message Segment: Required

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'20' Response Message	Mandatory
504-F4	Message	X(200)	A	Additional transaction specific messages.	Required

Response Status Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'21'- Response Status	Mandatory

112-AN	Transaction Response Status	X(1)	A	'A' - Accepted	Mandatory
503-F3	Authorization Number	X(20)	A	13 character Internal Control Number (ICN)	Required
130-UF	Additional Message Information Count	9(2)	N	Maximum count of 25. Currently limited to 9 due to current valid values for 132-UH.	Required if 526-FQ is sent.
132-UH	Additional Message Information Qualifier	X(2)	A	01=first line 02=second line 03=third line 04=fourth line 05=fifth line 06=sixth line 07=seventh line 08=eighth line 09=ninth line	Required if 526-FQ is sent.
526-FQ	Additional Message Information	X(40)	A	Additional message if needed	Required When

131-UG	Additional Message Information Continuity	X(1)	A	'*'=message continues	Required if and only if current repetition of Additional Message Informatio n (526-FQ) is used, another populated repetition of Additional Message Informatio n (526-FQ) follows it, and the text of the following message is a cont-inuaton of the current.

Response Claim Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'22' - Response Claim	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	X(1)	A	'1'-Rx Billing	Mandatory
402-D2	Prescription/Service Reference Number	9(12)	N	Prescription Number	Mandatory

Reversal Rejected Response

Response Header Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'B2' Reversal	Mandatory
109-A9	Transaction Count	X(1)	A	'1' - One Occurrence '2' - Two Occurrences '3' - Three Occurrences '4' - Four Occurrences	Mandatory
501-F1	Header Response Status	X(1)	A	'A' - Accepted	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-B1	Service Provider ID	X(15)	A	Pharmacy 10-digit National Provider Identifier (NPI)	Mandatory
401-D1	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory

Response Message Segment: Required

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'20' Response Message Segment	Mandatory
504-F4	Message	X(200)	A	Additional transaction information, if available.	Required

Response Status Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'21'Response Status	Mandatory
112-AN	Transaction Response Status	X(1)	A	'R' - Rejected	Mandatory
503-F3	Authorization Number	X(20)	A	13 character Internal Control Number (ICN)	Required

510-FA	Reject Count	9(2)	N	Max count of 5 per D.0.	Required
511-FB	Reject Code	X(3)	A	NCPDP Reject Code	Required
130-UF	Additional Message Information Count	9(2)	N	Maximum count of 25. Currently limited to 9 due to current valid values for 132-UH.	Required if 526-FQ is sent.
132-UH	Additional Message Information Qualifier	X(2)	A	01=first line 02=second line 03=third line 04=fourth line 05=fifth line 06=sixth line 07=seventh line 08=eighth line 09=ninth line	Required if 526-FQ is sent.
526-FQ	Additional Message Information	X(40)	A	Additional message if needed	Required When

131-UG	Additional Message Information Continuity	X(1)	A	'*'=message continues	Required if and only if current repetition of Additional Message Informatio n (526-FQ) is used, another populated repetition of Additional Message Informatio n (526-FQ) follows it, and the text of the following message is a cont-inuaton of the current.

Response Claim Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'22" - Claim Response	Mandatory
455-EM	Prescription/Service Reference Number Qualifier	X(1)	A	'1'-Rx Billing	Mandatory
402-D2	Prescription/Service Reference Number	9(12)	N	Prescription Number	Mandatory

Eligibility Reject Response

Response Header Segment: Required

Field	Field Name	Pic	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	'D0' – Version D.0	Mandatory
103-A3	Transaction Code	X(2)	A	'E1'Eligibility	Mandatory
109-A9	Transaction Count	X(1)	A	' 1' - One Occurrence	Mandatory
501-F1	Header Response Status	X(1)	A	'A' - Accepted	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	'01'- National Provider Identifier (NPI)	Mandatory
201-Bl	Service Provider ID	X(15)	A	Provider ID will be returned from the ID received on the request.	Mandatory
401-D1	Date of Service	9(8)	N	Date Filled Format=CCYYMMDD CC=Century YY=Year MM=Month DD=Day	Mandatory

Response Status Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'21'Response Status	Mandatory
112-AN	Transaction Response Status	X(1)	A	'R' - Rejected	Mandatory
510-FA	Reject Count	9(2))	A	Max of 5 allowed per D.0.	Required
511-FB	Reject Code	X(3)	A	NCPDP Reject Code	Required
549-7F	Help Desk Phone Number Qualifier	X(2)	A	Blank- Not Specified '03' - Processor/PBM	Required when
550-8F	Help Desk Phone Number	X(18)	A	'8005220114' AAA – Area Code EEE – Exchange Code NNNN – Number XXXXXXX - Extension	Required when

Transmission Rejected, Transaction Rejected Response

Response Header Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
102-A2	Version/Release Number	X(2)	A	Same value as in request	Mandatory
103-A3	Transaction Code	X(2)	A	Same value as in request	Mandatory
109-A9	Transaction Count	X(1)	A	Same value as in request	Mandatory
501-F1	Header Response Status	X(1)	A	'R' - Rejected	Mandatory
202-B2	Service Provider ID Qualifier	X(2)	A	Same value as in request	Mandatory
201-Bl	Service Provider ID	X(15)	A	Same value as in request	Mandatory
401-D1	Date of Service	9(8)	N	Same value as in request	Mandatory

Response Message Segment: Required

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'20' - Response Message Segment	Mandatory
504-F4	Message	X(200)	A	Additional transaction information	Required

Response Status Segment: Mandatory

Field	Field Name	Pic	Type	Value	Comments
111-AM	Segment Identification	X(2)	A	'21'Response Status	Mandatory
112-AN	Transaction Response Status	X(1)	A	'R' - Rejected	Mandatory 1 per transaction
510-FA	Reject Count	9(2)	N	Maximum count of 5 per D.0.	Required
511-FB	Reject Code	X(3)	A	NCPDP Reject Code	Required
130-UF	Additional Message Information Count	9(2)	N	Maximum count of 25. Currently limited to 9 due to current valid values for 132-UH.	Required if 526-FQ is sent.

132-UH	Additional Message Information Qualifier	X(2)	A	01=first line 02=second line 03=third line 04=fourth line 05=fifth line 06=sixth line 07=seventh line 08=eighth line 09=ninth line	Required if 526-FQ is sent.
526-FQ	Additional Message Information	X(40)	A	Additional message if needed	Required When
131-UG	Additional Message Information Continuity	X(1)	A	'*'=message continues	Required if and only if current repetition of Additional Message Informatio n (526-FQ) is used, another populated repetition of Additional Message Informatio n (526-FQ) follows it, and the text of the following message is a cont-inuaton of the current.

PRESCRIPTION PRICING FORMULAE

Prescription Formula Claim Request:
Ingredient Cost Submitted (4Ø9-D9)
+ Dispensing Fee Submitted (412-DC)
+ Incentive Amount Submitted (438-E3)
+ Other Amount Claimed Submitted (48Ø-H9)
+ Flat Sales Tax Amount Submitted (481-HA)
+ Percentage Sales Tax Amount Submitted (482-GE)
= Gross Amount Due (43Ø-DU)
- Patient Paid Amount Submitted (433-DX)
- Other Payer Amount Paid (431-DV)
(Result is Net Amount Due)

Note: Net Amount Due as defined above is applicable to primary and COB claims in which Other Payer Amount Paid (431-DV) is submitted. Net Amount Due for COB claim billings for Other Payer-Patient Responsibility Amount equals sum of the parts of other payer-patient responsibility amount(s).

Prescription Formula Response:
Ingredient Cost Paid (5Ø6-F6)
+ Dispensing Fee Paid (5Ø7-F7)
+ Incentive Amount Paid (521-FL)
+ Other Amount Paid (565-J4)
+ Flat Sales Tax Amount Paid (558-AW)
+ Percentage Sales Tax Amount Paid (559-AX)
- Patient Pay Amount (5Ø5-F5)
- Other Payer Amount Recognized (566-J5)

= Total Amount Paid (5Ø9-F9)

Compound Dosage Form Description Code

Blank=Not Specified
Ø1=Capsule
Ø2=Ointment
Ø3=Cream
Ø4=Suppository
Ø5=Powder
Ø6=Emulsion
Ø7=Liquid
1Ø=Tablet
11=Solution
12=Suspension
13=Lotion
14=Shampoo
15=Elixir
16=Syrup

17=Lozenge
18=Enema

Reason for Service Code

AD=Additional Drug Needed
AN=Prescription Authentication
AR=Adverse Drug Reaction
AT=Additive Toxicity
CD=Chronic Disease Management
CH=Call Help Desk
CS=Patient Complaint/Symptom
DA=Drug-Allergy
DC=Drug-Disease (Inferred)
DD=Drug-Drug Interaction
DF=Drug-Food interaction
DI=Drug Incompatibility
DL=Drug-Lab Conflict
DM=Apparent Drug Misuse
DS=Tobacco Use
ED=Patient Education/Instruction
ER=Overuse
EX=Excessive Quantity
HD=High DoseIC=Iatrogenic Condition
ID=Ingredient Duplication
LD=Low Dose
LK=Lock In Recipient
LR=Underuse
MC=Drug-isease (Reported)
MN=Insufficeint Duration
MS=Missing Information/Clarification
MX=Excessive Duration
NA=Drug Not vailable
NC=Non-covered Drug Purchase
ND=New Disease/Diagnosis
NF=Non-Formulary Drug
NN=Unnecessary Drug
NP=New Patient Processing
NR=Lactation/Nursing Interaction
NS=Insufficient Quantity
OH=Alcohol Conflict
PA=Drug-Age
PC=Patient Question/Concern
PG=Drug-Pregnancy
PH=Preventive Health Care
PN=Prescriber Consultation
PP=Plan Protocol
PR=Prior Adverse Reaction

PS=Product Selection Opportunity
RE=Suspected Environmental Risk
RF=Health Provider Referral