NCPDP D.0
ELIGIBILITY
OVERALL CHANGE REPORT

emdeon

NCPDP D.0 Eligibility Gap Analysis

Items in Red are flagged as Transitions Challenges

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Header	102-A2	Version/Release Number	Version release changed from 5.1 to D.0						
Header	103-A3	Transaction Code	Value E1						
Header	202-B2	Service Provider ID Qualifier	Value 00 removed, 15 and 16 added						
Patient	324-CO	Patient State/Province Code	Values YT,NT,NU,QC added, PQ removed. This field may be required if necessary for state/federal/regulatory agency programs.						
Patient	307-C7	Place of Service	Values 02 and 09 removed; 12 - 16, 20 - 26, 31 - 34, 41, 42, 49 - 57,60 - 62, 65, 71, 72, 81, 99 added. Required if the place of service could result in different coverage, pricing, or patient financial responsibility.						
Patient	384-4X	Patient Residence	Required if the patient's residence could result in different coverage, pricing, or patient financial responsibility.						
Pharmacy Provider	465-EY	Provider ID Qualifier	Value blank removed. This field is required when the Provider ID is (449-E9) is submitted.						
Prescriber	466-EZ	Prescriber ID Qualifier	Value blank and 07 removed, 15 added.						
Prescriber	467-1E	Prescriber Location Code	Removed in prior version						
Prescriber	468-2E	Primary Care Provider ID Qualifier	Value 00 and 07 removed, 15 added						
Prescriber	469-H5	Primary Provider Location Code	Removed in prior version						
Additional Documentation	369-2Q	Additional Documentation Type ID	Unique identifier for the data being submitted. Values 001-015						
Additional Documentation	374-2V	Request Period Begin Date	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	375-2W	Request Period Recert/Revised Date	Required if necessary for state/federal/regulatory agency programs. Required if the Request Status (373-2U) = “2” (Revision) or “3” (Recertification).						

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Additional Documentation	373-2U	Request Status	Required if necessary for state/federal/regulatory agency programs.						
Additional Docum	371-2S	Length of Need Qualifier	Required if Length of Need (370-2R) is used.						
Additional Documentation	370-2R	Length of Need	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	372-2T	Prescriber/Supplier Date Signed	Required if necessary for state/federal/regulatory agency programs.						
Additional Documentation	376-2X	Supporting Documentation	Required if necessary for state/federal/regulatory agency programs (using Section C of Medicare's CMN forms).						
Additional Documentation	377-2Z	Question Number/Letter Count	Maximum 50 occurrences. Required if needed to provide response to narratives.						
Additional Documentation	378-4B	Question Number/Letter	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form. Required if Question Number/Letter Count (377-2Z) is greater than zero (0).						
Additional Documentation	379-4D	Question Percent Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	380-4G	Question Date Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	381-4H	Question Dollar Amount Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	382-4J	Question Numeric Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Additional Documentation	383-4K	Question Alphabetic Response	Required if necessary for state/federal/regulatory agency programs to respond to questions included on a Medicare form that requires a percent as the response. (At least one response is required per question.)						
Response Header	103-A3	Transaction Code	Value E1						

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Response Header	202-B2	Service Provider ID Qualifier	Value 00 removed, 15 and 16 added						
Response Insurance Additional Information	139-UR	Medicare Part D Coverage Code	Required when needed to supply the provider with additional Medicare Part D Eligibility information. Used only in Eligibility Transaction. The value of the code is the pointer for the Other Payer Coverage Type (338-5C) in one of the response loops which designates the Medicare Part D coverage.						
Response Insurance Additional	138-UQ	CMS Low Income Cost Sharing (LICS) Level	Required when needed to supply the provider with additional Medicare Part D Eligibility information. Used only in Eligibility Transaction.						
Response Insurance	240-U1	Contract Number	Required if needed to identify the contract of the covered member. Used only in Eligibility Transaction.						
Response Insurance	926-FF	Formulary ID	Required if known to identify the formulary of the covered member. Used only in Eligibility Transaction.						
Response Insurance Additional	757-U6	Benefit ID	Required when known for Part D to identify the PBP (Plan Benefit Package) Number. Used only in Eligibility Transaction.						
Response Insurance Additional	140-US	Next Medicare Part D Effective Date	Required when future Medicare Part D coverage is known which is after the Date of Service submitted. Used only in Eligibility Transaction.						
Response Insurance Additional	141-UT	Next Medicare Part D Termination Date	Required when future Medicare Part D coverage is known which is after the Date of Service submitted. Used only in Eligibility Transaction.						
Response Patient Segment	29		New Segment added with D.0. This segment is used for Medicare Part D Eligibility transactions to provide patient name and date of birth in order to provide additional patient information. This information could assist in the verification that the eligibility information returned is indeed the patient for which the eligibility request was intended.						
Response Status	112-AN	Transaction Response Status	Value B added						
Response Status	510-FA	Reject Count	Maximum 5 occurrences in D.0. Version 5.1 allowed a maximum of 99 with 5 or less recommended. Used only when the response is either accepted/rejected (501-F1= 'A' & 112-AN= 'R' or when the response is rejected/rejected (501-F1= 'R' & 112-AN= 'R').						

Segment	Field	Description	Change Comment	New	Del	Qualifier	NCPDP Use	Code	NCPDP Siz
Response Status	511-FB	Reject Code	Values 1E,38,H5,RE,TE,and,UE were removed. Valued added were as follows:201,202,203,204,205,206,207,208,209,210,211,212,213,214,215,216,217,218,219,220,221,222,223,224,225,226,227,228,229,230,231,232,233,234,235,236,237,238,239,240,241,242,243,244,245,246,247,248,249,251,252,253,254,255,256,257,258,259,260,261,262,263,264,265,266,267,268,269,270,271,272,273,274,275,276,277,278,279,280,281,282,283,284,285,286,287,288,289,290,291,292,293,294,295,296,297,298,299,300,301,302,303,304,305,306,307,308,309,310,311,312,313,314,315,316,317,318,319,320,321,322,323,324,325,326,327,328,329,330,331,332,333,334,335,336,337,338,339,340,341,342,343,344,345,346,347,348,349,350,351,352,353,354,355,356,357,358,359,360,361,363,364,365,366,367,368,369,370,371,372,373,374,375,376,377,378,379,380,381,382,383,384,385,386,387,388,389,390,391,392,393,394,395,396,397,398,399,400,401,402,403,404,405,406,407,409,410,411,412,413,414,415,416,417,418,419,420,421,422,423,424,425,426,427,428,429,430,431,432,433,434,435,436,437,438,439,440,441,442,443,445,446,447,448,449,450,451,452,453,454,455,456,457,458,459,460,461,462,463,1R,1S,1T,1U,1V,1W,1X,1Y,1Z,2A,2B,2D,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W,2X,2Z,2G,2H,2J,2K,2M,2N,2P,2Q,2R,2S,2T,2U,2V,2W,2X,2Z,3Q,3U,3V,4B,4D,4G,4J,4K,4M,4N,4P,4Q,4R,4S,4T,4W,4X,4Y,4Z,5J,6D,6G,6H,6J,6N,6P,6Q,6R,6S,6T,6U,6V,6W,6X,6Z,7B,7D,7F,7G,7J,7K,7M,7N,7P,7Q,7R,7S,7T,7U,7V,7W,7X,7Y,7Z,8A,8B,8D,8G,8H,8J,8K,8M,8N,8P,8Q,8R,8S,8T,8U,8V,8W,8X,8Y,8Z,9B,9C,9D,9E,9G,9H,9J,9K,9M,9N,9P,9Q,9R,9S,9T,9U,9V,9W,9X,9Y,9Z,A1,A2,A5,A6,A7,AQ,BA,BB,BC,BD,BF,BG,BH,BJ,BK,BM,E2,EH,G1,G2,G4,G5,G6,G7,G8,G9,HN,K5,MG,MH,MJ,MK,MM,MN,MP,MR,MT,MU,MV,MW,MX,MY,NA,NB,NC,NF,NG,NH,NJ,NK,NP,NQ,NR,NU,NV,NW,NX,NY,N1,N3,N4,N5,N6,N7,N8,N9,PQ,PU,P0,RL,RQ,RR,RV,RW,RX,RY,RZ,R0,S0,S1,S2,S3,S4,S5,S6,S7,S8,S9,SA,SB,SC,SD,SF,SG,SH,SJ,SK,SM,SN,SP,SQ,TD,TF,TG,TH,TJ,TK,TM,TN,TQ,TR,TS,TT,TU,TV,TX,TY,TZ,T0,T1,T2,T3,T4,UA,UU,W0,W5,W6,W7,W8,W9,XZ,X1,X2,X3,X4,X6,X7,X8,X9,YA,YB,YC,YD,YE,YF,YG,YH,YJ,YK,YM,YN,YP,YQ,YR,YS,YT,YU,YW,YX,YY,YZ,Y0,Y1,Y2,Y3,Y4,Y5,Y6,Y7,Y8,Y9,Z0,Z1,Z2,Z3,Z4,Z5,Z6,Z7,Z8,Z9,ZA,ZB,ZC,ZD,ZK,ZM,ZN,ZP,ZQ,ZX,ZY,ZZ,UZ,U0,U7,VA,VB,VC,VD,VE,V0,ZD. Used only when the response is either accepted/rejected (501-f1= 'A' & 112-AN= 'R' or when the response is rejected/rejected (501-F1= 'R' &						

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Response Status	511-FB		112-AN= 'R'). Please also note that in the D.0 Telecommunication Guide section 26.1.2 it states the following, "Note: For syntax errors, the Reject Code (511-FB) of "R8 " must be used whenever a specific reject code is not designated. Specific reject codes must be returned whenever possible to assist in understanding the rejection."						
Response Status	130-UF	Additional Message Information Count	Maximum number of occurrences is 25. Required if Additional Message Information (526-FQ) is used. Used to qualify the number of occurrences of the Additional Message Information (526-FQ) that is included in the Response Status Segment.						
Response Status	132-UH	Additional Message Information Qualifier	Required if Additional Message Information (526-FQ) is used.						
Response Status	**526-FQ**	**Additional Message Information**	**The field length was reduced from 200 to 40 bytes and repeat functionality was added to allow for multiple messages. Messages with a length greater than 40 bytes will need to utilize 131-UG to indicate it is a continuation. For more detail and examples on the correct use of the message segment in the response please refer to section 28.2.5.3.2 Structured messages in the Telecommunication Standard Implementation Guide Version D.0.**						
Response Status	131-UG	Additional Message Information Continuity	Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.						
Response Status	550-7F		Value blank removed. This field is required when help desk contact information is populated in field 550-8F.						
Response Status	987-MA	URL	Provided for informational purposes only to relay healthcare communications via the Internet. This field is only used when the transaction status is accepted/rejected (501-F1= "A" & 112-AN= "R").						
Response COB and other payers segment	28		New segment added with D.0. This segment must NOT be returned if the response is a reject/rejected (501-F1= "R" & 112-AN= "R") see section. See sections 6.4.1.2.7 & section 6.4.2.2.6 of the Telecommunication Standard Implementation guide version D.0 for more detail.						
Response Coordination of	355-NT	Other Payer ID Count	Maximum 3 occurrences. Count of other payers with payment responsibility.						

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Response Coordin	338-5C	Other Payer Coverage Type	Values 04 - 09 added, 98 and 99 removed.						
Response Coordination of	339-6C	Other Payer ID Qualifier	Values 05 added, 09 removed. Required when field 340-7C is used.						
Response Coordination of	991-MH	Other Payer Processor Control Number	Required if other insurance information is available for coordination of benefits.						
Response Coordination of	356-NU	Other Payer Cardholder ID	Required if other insurance information is available for coordination of benefits.						
Response Coordination of	992-MJ	Other Payer Group Id	Required if other insurance information is available for coordination of benefits.						
Response Coordination of Benefits/Other	142-UV	Other Payer Person Code	Required if needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer.						
Response Coordination of	127-UB	Other Payer Help Desk Phone Number	Required if needed to provide a support telephone number f the other payer to the receiver.						
Response Coordination of Benefits/Other	143-UW	Other Payer Patient Relationship Code	Required if needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer.						
Response Coordination of	144-UX	Other Payer Benefit Effective Date	Required when other coverage is known which is before, on, or after the Date of Service submitted.						
Response Coordination of	145-UY	Other Payer Benefit Termination Date	Required when other coverage is known which is before, on, or after the Date of Service submitted.						