



Provider Manual

2026 V2.2



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Introduction

PharmaForce strives to partner with our clients to reduce costs, improve patient care, help patients live longer healthier lives, and coordinate health care with cutting-edge, proprietary technology. Our goal is to provide continuous improvement in the quality and efficiency of pharmacy benefit management to improve patient outcomes and financial performance.

Contact Information

Department	Phone/Fax	Email
Pharmacy Network & Contracting	F: (866)825-0007	PharmacyNetwork@thepharmacforce.com
Pharmacy Reimbursement Requests		
Pharmacy Grievances	N/A	RxGrievance@thepharmacforce.com
Pharmacy Technical Help Desk	P: (833) 379-1643	RxHelpDesk@thepharmacforce.com
Media Related Inquiries	P: (814) 788-2463	info@thepharmacforce.com
Fraud, Waste & Abuse	N/A	RxFWA@thepharmacforce.com

340B Program Overview

The 340B Program is a drug pricing program that was created and implemented under Section 340B of the Public Health Services Act, as amended, and related guidance and notices issued by HRSA and OPA, under which manufacturers that sell covered out-patient drugs at prices that do not exceed a statutorily determined price to eligible healthcare organizations, clinics, drug programs, hospitals and other safety net providers who qualify as a 340B covered entity or “HRSA Covered Entities”. Participating pharmacies should meet all Federal and State Laws, regulations, guidance, and notices relating to the 340B program as applicable.

Pharmacies who participate in the 340B pharmacy services will perform the following:

- Dispense outpatient drugs that are covered to patients in accordance with all applicable laws and regulations
- Perform drug utilization review (DUR)
- Support each Covered Entity’s formulary
- Maintain patient profiles for each Covered Entity
- Provide medication therapy management (MTM) and other clinical pharmacy services





- Counsel and advise each Covered Entity's patients in accordance with the rules, limitations, and privileges incident to the pharmacist-patient relationship
- Maintain and retain books, records, and reports (it can be in written or in electronic form) required under the 340B requirements
 - All books, records and reports shall be available for examination, inspection, or audit
- Establish, monitor, and maintain an inventory and dispensing tracking system suitable to prevent diversion of covered outpatient drugs to non-patients

PharmaForce will implement and maintain a system to verify patient eligibility under HRSA guidelines. Participating pharmacies will dispense 340B covered outpatient drugs only in the following circumstances:

- Upon receipt of a prescription identifying the applicable HRSA Covered Entity's name, patients name, a designation that the patient has received treatment at the HRSA Covered Entity and the signature of a prescriber that is associated with the HRSA Covered Entity; or
- Upon receipt of a prescription received via telephone or other means of electronic transmission that is permitted by law for a patient from a prescriber that is associated with the HRSA Covered Entity and states that the prescription is for an HRSA Covered Entity's patient

Participating pharmacies will implement and maintain written policies, procedures, and safeguards to avoid drug diversion and duplication of discounts that are associated with the 340B Program.

- Participating pharmacies will not dispense, sell, or otherwise transfer any covered outpatient drug or any other drug purchased at the program price of 340B to an individual who is not a qualified patient under the 340B program
- Participating pharmacies will not use cover outpatient drugs purchased under the 340B program to fill or to dispense Medicaid prescriptions unless the applicable HRSA Covered Entity, Participating Pharmacy, and the state Medicaid agency have established a written agreement or a process in place to prevent duplicate discounts
 - In the event the pharmacy establishes there has been a diversion or duplicate discounts, the pharmacy will notify PharmaForce as soon as possible and will collaborate with PharmaForce and the affected HRSA Covered Entity to remedy the problem
- Participating pharmacies accept that covered outpatient drugs are subject to specific pricing under applicable 340B laws.





- Participating Pharmacies will not directly or indirectly negotiate, contract, or agree with any pharmaceutical manufacturer or personnel for the purpose of obtaining rebates, discounts, financial incentives, price concessions, and other direct or indirect remuneration that will influence or impact utilization or volume of covered outpatient drugs

Participating pharmacies that purchase outpatient drugs that are owned or contracted with by safety-net institutions must submit claim values per the NCPDP Telecommunications Standard Guidelines.

Any action that violates the 340B agreement may result in termination with PharmaForce immediately upon written notice.

Point of Sale (POS) Claims Processing

BIN

Pharmacies submit with BIN number of **024269**.

PCN

Pharmacies submit with PCN of **PFORCE**

Electronic Claims Submission Window

Point-of-sale claims are typically submitted when a drug is dispensed at the pharmacy. On occasion, there may be an instance that requires a claim to be submitted after it is dispensed. However, transmitting a claim using the current date for a past date of service is a violation of this manual and could result in an audit error.

The standard timely fill limit from the date of service is 30 days for all initial claims, unless otherwise specified. Any claim that exceeds the fill limit will get denied with the NCPDP rejection code of 81 - Claim Too Old.

Submitting a Claim

The pharmacy is required to submit pharmacy claims electronically through PharmaForce's claims processing system for all covered items. For each claim, the pharmacy must also submit all necessary information requested on the payer sheet (see Appendix A), pharmacy agreement and required by the claims processing system.





All claims must be submitted completely and accurately in the current NCPDP D.0 HIPAA-approved format.

Submitting test claims is prohibited. Test claims are considered submitted claims used to confirm patient eligibility or to determine any coverage restrictions and/or the maximum amount of reimbursement.

Tennessee Claim Submission Requirement: Tenn. Comp. R. & Regs. 0780-01-95-.03 requires PharmaForce to request the wholesaler information for each prescription dispensed as part of our processing of claims for reimbursement. The purpose of this information is to allow pharmacy benefit managers to identify which pharmacies have claims that could result with an increased reimbursement when a reimbursement appeal from a pharmacy is granted and other network pharmacies are utilizing the same wholesaler. PharmaForce reimburses pharmacies exclusively at the drug level and does not factor in the drug wholesaler when determining reimbursement to a pharmacy. All PharmaForce network pharmacies are eligible for a drug's increased reimbursement if the date of service was on or after the effective date of a drug's increased reimbursement. PharmaForce encourages all network pharmacies to reverse and rebill a prescription for increased reimbursement regardless of who the pharmacy's wholesaler may have been at the time the prescription was dispensed. Pharmacies can contact our Pharmacy Technical Helpdesk to report wholesaler information for submitted pharmacy claims.

Prescription Requirements

Prescription hard copy means written prescriptions, refill authorizations, institutional orders, verbal or telephoned orders, facsimile order, prescription transfer and electronic prescriptions relied on by the prescriber at the time of dispensing. For a prescription to qualify as an electronic prescription it must be noted prior to dispensing and have a system assigned user, date, and time stamp on the hard copy documented. Prescriptions must be renewed at least annually, or more frequently as required by applicable state or federal law.

All documentation related to the original prescription record must be stored for at least three (3) years or longer as required by law.

To consider a prescription valid, it must include the following information at the time of dispensing:

- Patient's first and last name





- Patient's current address
- Patient's date of birth
- Date of issuance
- Prescribers full name, NPI number, and telephone number
 - If the prescription is for a controlled substance, it must include the prescriber's DEA number. If the DEA number is not included on the prescription hard copy, then the pharmacy is responsible for acquiring the DEA number by contacting the prescriber or from the pharmacy's claim system. The pharmacy must document the correct DEA on the prescriptions hard copy or prescription label that is placed on the back of the prescription hard copy
- Name and strength of the prescribed drug
- Quantity authorized by the prescriber
- Specific dosage directions
 - Directions may be obtained through direct communication with the prescriber and documented on the hard copy
- Substitution instructions with appropriate documentation
- Refill instructions
- Prescription number
- If the prescription is written for a drug that falls under a federally regulated program or REMS (example: iPledge), the provider must document the authorization number obtained from the program on the prescription hard copy prior to dispensing to the patient
- Documentation noting reason for filling a prescription early (example: lost/stolen)

PharmaForce suggests pharmacies document as much information as possible on the prescription, outlining any unique circumstances that arose while dispensing the drug. This documentation may eliminate any questions or discrepancy's that may come up during an audit.

Filling/Reversing a Claim

All claims must be submitted electronically through the PharmaForce claims processing system. PharmaForce does NOT accept paper submitted claims from pharmacy providers. Failure to submit a claim within the Plan's allotted billing window from the date of the fill may result in nonpayment of the claim.



Pharmacies are required to reverse any claim that is not received by the patient within 14 calendar days from the original submission date must be reversed or as specified by a particular governing requirements to assure prescriptions with inaccurate information.

Participating pharmacies are responsible for all covered prescription services that are utilized by the patient (drug is provided to a long-term care facility, the Pharmacy must maintain an agreement that any unused drug products are returned in accordance with law, and/or claims are reversed)

NDC and Package Size

Pharmacies are required to submit claims using the lowest ingredient cost dosage form and the lowest cost package/size container available. When pharmacies submit a claim, they must submit with the correct NDC for the medication dispensed to the patient. Pharmacies may be asked to prove purchase of an NDC during an audit review through the evaluation of wholesaler purchase invoices.

Drugs that are labeled, “to be dispensed only in the original container or package,” must be dispensing the original packaging for plans that cover that drug product. All other packages, such as lidocaine patches, insulin pens, etc. are considered “breakable” and must be dispensed for the quantity prescribed.

Insulin and Diabetic Supplies

When participating pharmacies are submitting a claim, they may only submit the NDC associated with the actual insulin or diabetic supply filled and dispensed with a prescription. Pharmacies may not submit Durable Medical Equipment (DME) products that are for non-retail use. Insulin, needles, and other diabetic supplies must reflect the prescribed directions and quantity accurately, manufacturer recommendations regarding storage and handling should be taken into consideration. If the directions are noted as needed, as directed, or the directions are without specific, calculable directions (example: use per sliding scale but not maximum daily dosage) require documentation on the prescription stating interaction was had with the prescriber. The documentation must include the date of the clarification(s) and the individual who provided that clarification.



Inhalers and Inhalation Products

If the patient's plan benefit allows and the prescriber writes accordingly, the pharmacy may dispense more than one inhaler per prescription depending on the patient's medical condition.

Anaphylaxis Treatment Device(s) i.e., EpiPen

If the patient's plan benefit allows and the prescriber writes accordingly, the pharmacy may dispense more than one device per prescription depending on the patient's medical condition.

Ophthalmic and Otic Products

Unless a more specific drop per mL or uses/package exists, eye and ear drops should be calculated using the industry standard of 15 drops per mL of solution/suspension. A prescription with a defined length of therapy may use that period for days' supply when the smallest package size available in the market is used.

GTTS/Day	2.5 mL	5 mL	10 mL	15 mL
One	37	75	150	225
Two	18	37	75	112
Three	12	25	50	75
Four	9	18	37	56

Note: If the minimum quantity from the manufacturer is being dispensed and causes a rejection, with notation of a maximum days' supply, the pharmacy may resubmit with the maximum day supply transmitted from the rejection which represents the plan maximum.

Repackaged/Relabeled Products

PharmaForce allows the original manufacturer NDCs only. PharmaForce does not allow repackaged products to be submitted and will reject any repackaged or relabeled NDC. Any claims for repackaged and/or relabeled NDCs submitted through the PharmaForce claims system will be subject to full audit recovery.

Quantity Dispensed

Participating pharmacies must dispense the quantity authorized on the prescription by the prescriber and as allowed by state law or up to the patient's plan limitation. For proper reimbursement, the actual and allowed quantity dispensed to the patient should be submitted in the "Quantity Dispensed" NCPDP field (442-E7).





For drugs that have NDC numbers that are packaged in sizes that are not whole numbers, pharmacies must submit the claim with the exact metric decimal. It should never be rounded up or down.

- If a prescription that is written for a quantity of one, but it is a metric decimal (examples: eye drops, inhalers, and topical agents) pharmacist at the pharmacy should dispense the smallest commercially available product. If a larger package size is dispensed, it must be documented on the hard copy of the prescription or within the pharmacies system that it was verified with the prescriber
 - Examples:
 - Symbicort 160/4.5 Inhaler
 - One inhaler = 10.2 grams
 - Quantity dispensed should reflect 10.2
 - Hydrocortisone 2.5% Ointment
 - One tube = 28.35 grams
 - Quantity dispensed should reflect 28.35

The units that are utilized in billing to describe the drugs are:

- EA- each
- mL-milliliters
- gm-grams

Drugs that are measured in units rather than weight or volume are to be billed and dispensed as “EA-each”.

- Common dosage forms are tablets, capsules, transdermal patches, non-filled syringes and reconstitutable injectable vials. These dosage forms should be displayed as the number of units dispensed in the “Quantity Dispensed” field.
 - Example: 45 patches dispensed
 - Quantity dispensed should reflect 45
 - Example: 30 capsules dispensed
 - Quantity dispensed should reflect 30

Drugs such as solutions, syrups, and injectables are measured by liquid volume. Liquid volume is billed as “mL-milliliters”





- Common dosage forms that are measured as liquid volume include suspensions, solutions, reconstituted non-injectable liquid dosage form, IV solutions, nasal sprays, oral inhalers, etc. These dosage forms should be displayed as the exact number of milliliters dispensed in the “Quantity Dispensed” field. If the quantity is a metric decimal, the metric decimal quantity should be in the “Quantity Dispensed” field.
- Example:
 - Albuterol 0.083% Inhalation Solution 2.5 mg/3 ml (Box of 25 x 3 ml)
 - Quantity dispensed should reflect 75
 - Enoxaparin 60 mg/0.6 ml syringes
 - 12 Syringes dispensed
 - Quantity dispensed should reflect 7.2 (0.6 x 12)

Ophthalmic drops, oral antibiotics, and other non-injectable dosage forms that must be reconstituted prior to dispensing and are labeled by volume should be shown as mL-milliliters

- These types of medications should be displayed as the exact number of milliliters dispensed in the “Quantity Dispensed” field. If the quantity is a metric decimal, the metric decimal quantity should be in the “Quantity Dispensed” field.
- Penicillin-VK suspension 200 mL (200 x 1)
 - Quantity dispensed should reflect 200

Drugs that are measured by weight will be billed as the number of grams being dispensed. These drugs are labeled with grams on the package. Examples exclude ointments, creams, bulk powders, inhalers, and so forth.

- These types of medication should be displayed as the exact number of grams dispensed in the “Quantity Dispensed” field. If the quantity is a metric decimal, the metric decimal quantity should be in the “Quantity Dispensed” field.
- Example:
 - Lotemax 0.5% Ophthalmic Ointment – 3.5 g
 - Quantity dispensed should reflect 3.5
 - Hydrocortisone 2.5% Ointment – 28.35 g
 - Quantity dispensed should reflect 28.35
 - Testosterone 1% (50 mg/5 g) Gel Packets





- Dispensed 15 packets containing 5 grams (15 x 5) = quantity dispensed should reflect 75
- Exception:
 - Pulmicort 90 mcg Flexhaler – 1 inhaler
 - Quantity dispensed should reflect 1

Additional clarification and exceptions:

- Quantities that are dispensed from an open container should indicate the amount of fill volume containing the actual drug. This should be expressed in milliliters
 - Example: Q-Dryl 12.5 mg/5 mL oral Elixir – 120 mL dispensed out of a 473 mL bottle
 - Quantity dispensed should reflect 120
- Drugs that are powder-packets such as Cholestyramine, should be displayed by the number of packets
 - Example: Cholestyramine – 45 packets dispensed
 - Quantity dispensed should reflect 45
- Enemas that are labeled by volume will be dispensed in milliliters, if it is not labeled by volume, the quantity dispensed will be displayed as the number of units dispensed
 - Example: Mesalamine Rectal Suspension USP Enema
 - Quantity dispensed should reflect 60
- Drugs that are packaged as a combination and the drugs have different dosage forms should be expressed as units of 1 kit
 - Example: DUAC CS Convenience Kit, Copaxone
- Convenience packets, therapy packs and prepackaged drugs must be billed as the number of tablets or capsules dispensed and not the number of boxes or packages
 - Example:
 - Chantix Continuing Month Pak – Package Size 53
 - Quantity dispensed should reflect 53

Unbreakable Packages

An unbreakable package or unit of use package is a prescription drug that cannot be sub-divided into fewer dispensed quantities or contain a quantity designed and intended to be dispensed directly to a patient for a specific use without modification, except for the addition of a prescription label by a dispensing pharmacist.





Participating pharmacies should process the medication for multiples of whole packages with the true days' supply and allow it to reject prior to reducing the days' supply and/or quantity. If the drug is written for a quantity that calculates to be greater than the plan will allow, the quantity must be reduced to meet the plan limits.

Days' Supply

The Days' Supply field (NCPDP field 405-D5) is reference for Drug Utilization Review (DUR) and Early Refill edits. If an incorrect days' supply is input, it can result in inaccurate DUR alerts and cause to claim to reject for early refill (Refill too soon). Any claims submitted through the PharmaForce claims system with the incorrect days' supply based on the directions of the prescription will be subject to audit recovery.

Refills

The pharmacy shall not process an automatic refill for a prescription for an eligible patient unless or until the refill has been requested and authorized by the eligible patient.

Compound Claims

The pharmacy must submit the correct amount with corresponding accurate quantities and days' supply calculations based on a valid prescription for the member. The pharmacy must submit all ingredients that make up a compound drug on the same claim. The most expensive ingredient will display at the claim level. Edits are returned for each ingredient based on the member's benefits.

The pharmacy shall not attempt to circumvent a plan's benefit design or engage in inappropriate billing practices of compound drugs. Such practices include, but are not limited to:

- Submitting test claims for a compound drug;
- Submitting a claim multiple times with variations in the ingredients, ingredient cost, dispensing fees, quantity amount and/or days' supply to obtain the highest reimbursement possible;
- Resubmitting rejected compound prescription ingredients as individual, non-compounded ingredients; and
- Submitting partial fills or multiple claims for fills that are less than a 30-day supply to avoid coverage limitations or gain additional reimbursement or copayment amounts.

NCPDP Submission Clarification Code (SCC) 08 cannot be used to override the nonformulary compound rejection.

Experimental and Investigation Services Excluded

PharmaForce does not cover drug therapies, medications, treatments, or formulations of drugs that are not approved by the US Food and Drug Administration (FDA). PharmaForce will not pay





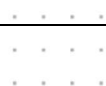
for drugs used for purposes other than their FDA indication(s) or prescribed for off-label use only if the drugs are identified as safe and effective for that use in one of three officially recognized drug compendia.





DAW Codes & Descriptions (408-D8)

DAW Code	Description
0 – No Product Selection Indicated	Used for prescriptions where the selection is not an issue. Examples include prescription written for a single source brand (SSB) drug and prescription written using the generic name and a generic drug is dispensed.
1 – Substitution Not Allowed by Prescriber	Used when the prescriber indicates that the drug is to be Dispensed As Written (DAW)
2 – Substitution Allowed – Patient Requested Product Dispensed	Used when the prescriber has indicated that generic substitution is permitted, and the patient requests the brand drug. This can occur when the prescriber writes the prescription using either the brand or generic name and the drug is available from multiple sources
3 – Substitution Allowed – Pharmacist Selected Product Dispensed	Used when the prescriber has indicated generic substitution is permitted, and the pharmacist determines that the brand drug should be dispensed. This can happen when the prescriber writes the prescription using either the brand or generic name and the drug is available from multiple sources
4 – Substitution Allowed – Generic Drug Not in Stock	Used when the prescriber has indicated that generic substitution is permitted, and the brand drug is dispensed since a currently marketed generic is not stock in the pharmacy. This is due to the pharmacy not having the generic product in stock.
5 – Substitution Allowed – Brand Drug Dispensed as Generic	Used when the prescriber has indicated that generic substitution is allowed, and the pharmacist is utilizing the brand drug as a generic
6 – Override	Used by various claims processors in specific instances. The claim's processors or the clients define this
7 – Substitution Not allowed- Brand Drug Mandated by Law	Used when the prescriber has indicated that generic substitution is permitted, but prevailing law or regulation prohibits the substitution of a brand drug even though generic products may be available in the marketplace



DAW Code	Description
8 – Substitution Not Allowed-Generic Drug Not Available in Market place	Used when the prescriber has indicated that generic substitution is permitted and the brand drug is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable
9 – Other	Used in conjunction with the Brand/Generic Program. Pharmacies should use this DAW code when the member’s formulary restricts a particular drug to the Multi-Source Brand product.

Brand for Generic Program

Prescription Origin Codes

Participating pharmacies must accurately submit the Prescription Origin Code in conformance with NCPDP standards (419-DJ).

- 1 = Written
- 2 = Telephone
- 3 = Electronic
- 4 = Facsimile (Fax)
- 5 = Transfer

Prescription Sales Tax

If any taxes, assessments and/or similar fees (taxes) are required on the pharmacy by governmental authority based on the pharmacies provision of prescription drugs to eligible patients, the pharmacy may request reimbursement from the payer or eligible patient for such taxes that are allowed and imposed by applicable law. The pharmacy must transmit the applicable tax amount allowed by law through the claims processing system (481-HA, 482-GE, 483-HE, and 484-JE). This does not give the pharmacy any additional or different rights than those allowed by law. PharmaForce will not be liable for any such taxes, assessments or similar fees or the determination of the amount of such taxes, assessments, or similar fees.

Online Claim Billing Requirements

Pharmacies are required to submit claims electronically through the claims processing system in the NCPDP Version D.0 format. Pharmacies are required to submit claims with a valid prescriber

NPI number, BIN/PCN, member identification number (Cardholder Id), and RxGroup number on all pharmacy claims. Please refer the Payer Sheet located in Appendix A for more information.

PharmaForce does not accept paper claims submission from pharmacy providers.

Common Rejections seen in claims Processing

Following an electronic claim submission by the participating pharmacy, the PharmaForce adjudication system will send a response back to the pharmacy to indicate the outcome. If the claim passes all claim edits, the pharmacy will receive a paid response which will include the allowed amount for the paid claim. If the claim does not pass all the claim edits, the pharmacy will receive a reject response along with the NCPDP rejection code.

Scenarios	Claim Response	Action to Resolve
Initial claim was submitted and picked up 7/1/2024 for Drug X with a quantity of 30 tablets per 30 days, on 7/15/2024 Drug X was submitted for a quantity of 30 tablets per 30 days	Claim will reject with 79-Refill too soon	Resubmit claim on or around 7/29/2024.
Initial claim was submitted and picked up on 7/1/2024 for Drug X with a quantity of 30 tablets per 30 days, on 7/16/2024, Drug X was submitted for a quantity of 60 tablets per 30 days starting on 7/6/2024	Claim will reject with 79-Refill too soon	Contact PharmaForce pharmacy technical helpdesk to determine if override is available due to a dosage increase.
Claim was submitted with a cardholder ID of 123456	Claim will reject with 07-M/I Cardholder ID	Resubmit claim with Member Prefix and ensure the numbers are correct.
Claim was submitted with an other coverage code of anything but a 0, 1 or 8	Claim will reject with 535-Other Coverage Value Not Support	Resubmit claim with the appropriate other coverage code of 0, 1, or 8.
Claim was submitted without an other coverage code	Claim will reject with 13-M/I Coverage Code	Resubmit claim with the appropriate other coverage code of 0, 1, or 8.
Claim was submitted without a group number	Claim will reject with 51-Non-Matched Group ID	Resubmit claim with correct Group ID.

Scenarios	Claim Response	Action to Resolve
Claim submitted for a medication that is not covered on formulary or on the drug price file	Claim will reject with 70-Product/Service not covered	<p>Contact prescriber to inform medication is not covered. The medication would need to be changed, or a prior authorization would be required. A prior authorization does not apply to RxSavingsCard (cash card).</p> <p>Note: By submitting a prior authorization for the medication, which does not automatically mean the medication will be covered.</p>
<p>Claim is submitted for a quantity that is over the plan limit.</p> <p>Example: The plan limit is a quantity of 30. Claim is submitted for 90 tablets per 90 days.</p>	Claim will reject with 76-Plan limits exceeded	<p>Submit with the quantity that is within the plan limit. Ensure days' supply is accurate.</p> <p>Example: Resubmit claim for 30 tablets per 30 days</p>
Claim is submitted for John Doe, however the cardholder ID submitted is for Jane Doe	Claim will reject with 62-Patient/Cardholder ID Name Mismatch	Resubmit the claim with John Doe's correct cardholder ID.
Claim is submitted on 7/15/2024 at pharmacy NPI: 123456789. Pharmacy is not contracted.	Claim will reject with 40 - Pharmacy not contracted with plan on Date of Service	Patient will need to take their prescription to a pharmacy that is contracted. Contact the PharmaForce Pharmacy Network team if you question network participation status.
Claim is submitted on 7/15/2024 and the prescriber is Owen Smith, NPI: 987654321. Prescriber is not contracted	Claim will reject with 71 - Prescriber is not covered	Patient will need to obtain a new prescription from a prescriber that is in the patient's prescriber network.
Claim is submitted for a date of service of 6/1/2024, today's date is 7/15/2024.	Claim will reject with 81 - Claim too old	Claim is outside of billing window and needs to be billed within 30 days from today's date, unless otherwise specified. Contact the

Scenarios	Claim Response	Action to Resolve
		PharmaForce pharmacy technical helpdesk to determine if override is available.
Claim is submitted for Medication X and it costs \$5,000. Group's Maximum cost is set to \$2,500.	Claim will reject for 78 - Cost exceeds maximum	Contact the PharmaForce pharmacy technical helpdesk to determine if override is available. A prior authorization may be required.
Claim is submitted for patient John Doe on 7/15/2024. Member is not active on that date of service	Claim will reject for 65 - Patient is not covered	Verify with patient who their prescription insurance is through and obtain new insurance information.

Member Eligibility

ID Cards & Example

Plan patients are provided with identification cards and will show coverage for eligible patients only. The Identification card is designed utilizing the NCPDP format and provides the pharmacy with a Cardholder ID number, BIN, PCN, Group, Person/Relationship Code.

The pharmacy is required to request the ID card from the patient and utilize the information on the card to submit claims for claims processing. Pharmacies will not be reimbursed for rendering pharmacy services to patients whose eligibility was not correctly submitted, nor will patients be reimbursed through their direct member reimbursement (DMR) process.

Collection of Eligible plan patient pay amounts

The amount determined by the Plan Sponsor is the copayment amount which the pharmacy is required to collect from the eligible patient for the pharmacy services related to a covered drug. The copayment amount per eligible payment may vary from plan or plan sponsor. The pharmacy is required to collect from the patient the copayment amount indicated by the claims processing system. The pharmacy cannot waive, discount, reduce or increase the patient copayment amount determined by the claims processing system. If it is determined that the pharmacy has charged or collected more than the patient's copayment amount determined by the claims processing system, the pharmacy must immediately reimburse the patient. If the pharmacy does not reimburse the patient, PharmaForce has the right to recover any excess amounts or unauthorized

fees from the provider and return the recovered amounts to the patient. Failure to collect the exact amount of patient cost share from the adjudicated response may result in the pharmacy's termination from the PharmaForce pharmacy network.

Person Code/Relationship Code

A person code or relationship code is required. The person code field is a two -digit numeric entry. Please refer to the patient's ID Card for this information.

Formulary

Payors will utilize a formulary to help with cost-containment and quality of care. Formularies may vary from Plan Benefit and change regularly. Formularies are provided as references for drug therapy selections.

If a medication is not covered due to it being non-formulary, the pharmacy should try to contact the prescriber to ask if the prescription can be changed to a medication that is covered on formulary.

Quantity Limit

On a formulary, a medication could have a quantity utilization management (UM) requirement of Minimum or Maximum Quantity limit, Quantity per day, quantity over time and maximum daily dose. All these limits could be plan/group specific.

Days' Supply

On a formulary, a medication could have a days' supply maximum that is defined by the plan benefit or group. The plan may allow up to a 90-day supply, 30-day supply or less. This limit may vary per plan/group and may vary by covered drug.

Coordination of Benefits

PharmaForce is typically the primary payer, however, there are times clients request that they be the secondary payer. Coordination of Benefits (COB) is used to define the order in which multiple carriers are responsible for benefit payments, in which prevents duplicate payments.

PharmaForce only accepts electronic COB in accordance with the NCPDP D.0 Standards. The COB segment is required to submit secondary claims. At this time, only the COB values of 0,1, and 8 are accepted as PharmaForce is only utilizing the Other Payer Patient Responsibility Amount

(OPPRA) COB method at this time. Participating pharmacies must accurately coordinate the patient's benefits and submit to both primary and secondary claims as direct by the patient in compliance with applicable laws and regulations.

NCPDP Field: 308-C8	
Value	Definition
0	Not Specified by Patient
1	No Other Coverage
8	Claim is Billing for Patient Financial Responsibility Only

Pharmacy Network

Participating Pharmacy Responsibilities

Participating pharmacies are responsible for:

- Notifying PharmaForce of changes of location, ownership or any change that could impact the patient's access to the pharmacy
- Comply with all laws and provide service complaints with the highest standards with compliance such as HIPAA, what information is used within the organization and what information is disclosed outside of the organization
- Reasonable verification of the member or member's representative
- Accurately fill prescriptions per the prescriber's directions, if any questions or changes are needed coordinate with the prescriber
- Inform patients or patient representatives of drug recalls
- Provide instructions to the patient or patient's representative regarding storage, dosage, side effects, potential interactions, and the use of the medication dispensing in accordance with its practice guidelines (package insert)
- Maintain a log of all prescription errors and potential injuries resulting from dispensing errors
- Utilize accurate NPI numbers in correspondence with the pharmacy and prescriber and ensure the correct NCPDP data fields are filled in
- Conduct prospective drug utilization review at point of sale
- Adhere to point of sale reject and supplemental messages from adjudicated claims
- Charging the patient anything other than the claim response
- Adhere to accepted industry standards, contractual requirements as outlined in the provider agreement, and all requirements contained in this provider manual.

Participating pharmacies are to not serve as an appointed representative for a member surrounding the submission of prior authorizations, grievances, or appeals.

Pricing Information

PharmaForce contracts with drug data vendors such as First Databank® (FDB) and Medi-Span® by Wolters Kluwer as sources for drug information including pharmaceutical pricing information. The drug unit price benchmarks that PharmaForce uses include, but are not limited to, AWP, NADAC, FUL, and WAC as set forth in the Pharmacy Service Agreement (PSA) for determining reimbursement.

Maximum Allowable Cost (MAC) Pricing

At this time MAC pricing other than NADAC and FUL is not utilized by PharmaForce. PharmaForce does not maintain nor manage lists that are traditionally used for MAC pricing reimbursement to pharmacy providers.

Submission of the Pharmacy's Cash Price as Usual & Customary (U&C)

Participating pharmacies must submit all claims to PharmaForce with the cash price charged to patients for all covered prescription services dispensed to patients as the pharmacy's U&C price in their claim adjudication. The U&C or cash price is the total amount charged to a patient at the time of dispensing the medication for the same drug including all applicable discounts such as sales price, price matching, coupons, senior citizen, or any other discounts a cash paying patient would pay the participating pharmacy for the medication, device, product and/or supplies including those which are offered by the participating pharmacy without cost (example: U&C is \$0.00, the U&C submitted should be \$0.00). The NCPDP field used to transmit the pharmacy's U&C price is 426-DQ.

Maintenance of Records

Participating pharmacies are required to gather and maintain complete, accurate, up-to-date records related to the provision of Prescription Drug Benefits to patients and ensure conformance with accepted standards and good pharmacy practice. The documents and records should include, but are not limited to:

- Original Prescription(s)
- Signature and/or electronic tracking logs
- Daily prescription logs



- Wholesaler, manufacturer, and distributor invoices
- Refill information
- Prescriber information
- Patient profiles/doctor orders

Participating pharmacies agree in accordance with applicable law, PharmaForce or their designated representatives, State Authorities, the Comptroller General and/or any of their designees shall have the right to inspect, evaluate and audit all records/documents related to the services performed or determination of amounts payable under these terms and related to quality of care or investigating the grievances or complaints of members.

Participating pharmacies agree to store all documents related to the services by these terms for a period of no less than ten (10) years from the expiration or from the completion of any audit contemplated by the terms below or as required by law, whichever is later unless: (1) it's determined by PharmaForce there is a special case to keep a particular record or group of records for a longer period, (2) there's a termination, dispute or accusation of fraud, which may cause the retention to be extended to six (6) years from the date of any final resolution of the termination, dispute or fraud, (3) PharmaForce has reason to believe there is fraud, in which results in an audit of the participating pharmacy. Participating pharmacies are required to maintain prescription records in their original format for the greater of three (3) years or the period required by state laws. Those records may be transferred to an electronic format for the remaining seven (7) years.

Pharmacy Required to Validate Product Sources

Participating pharmacies are to validate the quality of all products purchased from their wholesaler for dispensing to patients to ensure compliance with the law, principles of good manufacturing practices, good distribution practices and ethical conduct. If requested from PharmaForce, participating pharmacies will be required to provide a list of their wholesalers, product pedigree documents, proof of origin of products, or equivalent documentation regardless if the products are prescription drugs, over-the-counter drugs or DME. For DME and medications classified as specialty drugs, it is the participating pharmacies responsibility to ensure the medications are purchased from authorized suppliers to distribute to patients.

Collection of Patient Cost-Sharing Amount

Participating pharmacies must charge the patient the cost-share amount indicated in the online response from PharmaForce and only this amount. Waiving or adjusting the amount associated



with the patients' cost-share is strictly prohibited, unless required by law. Waiving or adjusting the amount associated with the patient cost-share may be considered a material breach of the agreement.

Pharmacy reimbursement pricing as well as prices paid to the pharmacy for each individual claim under this agreement are confidential and proprietary information. This information may not be disclosed on patient receipts or insurance profiles except for U & C Pricing. Participating pharmacies may print U & C prices and patient pay amount on patient's insurance profile as well as the receipts.

Participating pharmacies shall not under any circumstances, charge, seek compensation, or reimbursement from any patient or other person acting on the patient's behalf. The exceptions to the above are Cost-Share Amounts and reasonable returned check costs and reasonable collection costs related to subparts in cost sharing or reasonable returned check costs. This section shall live through after expiration or termination of the agreement.

Pharmacies owned or contracted with a 340B entity may discount or waive the cost sharing amounts owed by patients for reasons of genuine financial need as outlined by the US Department of Health & Human Services, Health Resources Services Administration (HRSA) rules & requirements.

Pharmacy Reimbursement Appeals

Participating pharmacies may request reimbursement appeals by contacting PharmaForce's pharmacy network department. Appeals can be found on our website at <https://pbm.thepharmaforce.com/pharmacies>. These forms can be faxed to 1-866-825-0007 or emailed to PharmacyNetwork@thepharmaforce.com.

Participating pharmacies may not refuse to dispense a prescription to an eligible patient solely based on what the pharmacy considers as under-reimbursement for the prescription. Failing to dispense a prescription due to the reimbursement amount received by the pharmacy may be considered a material breach of the pharmacy service agreement. Pharmacy providers should follow the PharmaForce reimbursement appeals process in these situations.

Pharmacy Audits

Participating pharmacists must cooperate with PharmaForce's auditors and provide access to all information and documents needed in a timely manner that is deemed necessary by the

auditors. This would include hard copies of the prescription, signature logs from the patient, purchase invoices and documentation. Advanced notice is provided to pharmacies, unless otherwise specific in their contract, as required by applicable state/federal law or if a suspected fraud has been identified. Pharmacy records may be requested and reviewed by PharmaForce at any time as outline in the pharmacy services agreement.

The criteria that we use while conducting on-site and/or desktop audits include, but are **not** limited to:

- Excessive quantity dispensed for the days' supply limitation
- Early refill
 - Duplicate dispensing for school/work
- Medication billed is different than that dispensed
- Package billing errors
- Billing for the incorrect patient/prescriber
 - Utilizing an NCPDP/NPI number inappropriately
- DAW parameters
- Duplicate therapy
- Temporary supply
- Diagnosis code
- Over/under billing quantities
- Improper documentation of authorized changes to the order
- Large volume of controlled substances or other medications associated with FWA

Retrospective Claims Review

Claims that are processed through the PharmaForce claims processing are run through a proprietary software program that utilizes algorithms to flag adjudicated claims for potential errors.

PharmaForce's Pharmacy Services department will review these claims and contact the pharmacy via phone, fax or email surrounding these flagged claims to request these claims be reviewed or reprocessed by the pharmacy.



The Pharmacy Services department will work with the pharmacy and educate and correct claims if applicable prior to processing for payment as the claim review is not an audit. This process does not stop the claim from paying and there is no access to care issues for the patient.

Desktop Audits

After the initial notification of the audit, the pharmacy will be sent a notification requesting the copies of specific prescriptions and signatures logs which must be provided no later than 30 calendar days of that notification. This information may be provided back to PharmaForce by Email or Fax with the contact information provided in the audit notification.

After receipt and review of the claims, notification will be provided back to the pharmacy with preliminary audit results. The pharmacy will then be allowed up to thirty (30) calendar days to appeal the results.

Onsite Audits

Participating pharmacies that are selected for an onsite audit will receive notification no later than thirty (30) days prior to the audit or as required by applicable state/federal law or if suspected fraud has been identified. The notification to the pharmacy will include date and time of the audit, a photograph of the auditor, and the pharmacy records required such as prescription numbers, invoices, etc.

Onsite audits will be completed during the pharmacy's normal business hours. The auditor will come to the pharmacy in person to review the requested documentation within the notification. The auditor will review and verify licenses, certifications, and procedures. Any documentation will need to be provided by pharmacy staff and must be out of sight and hearing range of the pharmacy's customers. The auditor may request prescriptions and supporting documentation to be copied or scanned as permitted under HIPAA for operations and payment.

After receipt and review of the claims, notification will be provided back to the pharmacy with preliminary audit results within 30 days or as required by applicable state/federal law.

Signature Logs

Participating pharmacies are required to maintain a signature log for all claims processed in chronological order as prescriptions are received by the patient, including off-site delivery with the following information: Patient Name, Prescription Number, Third Party Program, member (or legal representative) signature and date prescription is picked up.



Signature logs or proof of service must be retained for ten (10) years. This timeframe may vary per applicable laws. The pharmacy should ensure its process incorporates all state requirements.

Purchase Records

Purchase records for wholesalers, manufacturers, and distributors must be maintained for a minimum of three (3) years or required by applicable law that the drug dispensed to the patient was purchased from an authorized source. These records may be requested by PharmaForce to facilitate the verification of the purchases. The participating pharmacy is to provide these records promptly, failure to do so may result in a 100% charge back any paid claims in question.

PharmaForce will only accept purchase records directly from the pharmacy's wholesaler(s).

Pharmacy Audit Appeals

Participating pharmacies will have thirty (30) calendar days from the date of the preliminary results letter to review the claim(s) in question and challenge the results by providing supporting documentation from the onsite or desk audit. Appeals must be submitted in writing. Please go to website at <https://pbm.thepharmaforce.com/pharmacies> for the appeal form. Multiple appeals on the same claim will not be considered. The pharmacy should provide one appeal for each claim that is in question.

Appeal documentation that is considered acceptable include: prescriber notes and letters, written and electronic documentation of changes made to the original hard copy with specific dates or other items that support the claim in question. Any statement from the prescriber must be on the prescriber's letterhead. If it is not on the prescriber's letterhead it will not be accepted. Any statement from the patient should include the patient's address and phone number, drug name, prescription number, date of service and the patient's signature and date.

After thirty (30) calendar days appeals will not be accepted, no exceptions. After the appeal timeframe has closed, the pharmacy will be notified of the final audit results. Appeal periods may vary depending on state guidelines/regulations and/or client requirements.

Pharmacy Audit Resolutions

Any amount owed to PharmaForce for inconsistent claims, overpayment, or claims that are not compliant and audit related costs will be offset against the amount PharmaForce owes to the pharmacy until the amount is paid in full. The pharmacy may also elect to submit a check or EFT payment for the full amount due from an audit recovery in lieu of offsetting with future invoice

payments to the pharmacy. Failure to pay PharmaForce for an invoice due to audit findings may result in suspension or termination from participation with PharmaForce.

Participating pharmacies cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any retaliation against an eligible patient or plan sponsor in relation to an adjustment or chargeback due to an audit discrepancy.

Audit findings may be reported to plan sponsors, appropriate government entities, regulatory agencies, professional review and audit organizations, and other such entities.

Overpayments & Recoveries

A recovery of an overpayment or takeback means that the amount of money received for a covered pharmacy benefit by a participating pharmacy is in excess of the calculated price less applicable coinsurance, copayment, deductible, or the amount of money paid for on behalf of an individual that is considered an inaccurate payment for that date of service or fraud and abuse was identified. Inaccurate payments include duplicate payment, system set-up error, claim processing error, claims paid to the wrong provider, incorrect member, or any other payment that was received or applied to the pharmacy in error.

If it is deemed that an inaccurate payment has been made, PharmaForce will not provide separate written notice of a recovery to the pharmacy. The overpayment will be recovered by issuing an invoice or completing a take-back. Full details of the recovery will be provided by an invoice or remittance advice statement.

Inaccurate payments will be limited to twelve (12) months from the date of payment and there is no time limit that applies to the initiation of overpayment where there is suspected fraud, abuse or intentional misconduct involved.

Pharmacy Complaints/Grievance Process

It is encouraged for any complaints or grievances that the participating pharmacy contact PharmaForce via email at RxGrievance@thepharmaforce.com. If the pharmacy would prefer, they can go to website to fill out a pharmacy provider complaint form. A complaint is a statement of unhappiness or dissatisfaction with something other than a medical necessity determination. It is not considered a complaint if it is a matter of a misunderstanding or misinformation that can be quickly resolved by clearing up the misunderstanding or misinformation by providing the correct information. A grievance is any dissatisfaction about anything other than an action. Examples of



grievances include quality of care or services provided, aspects of interpersonal relationships (example: an employee was rude) or failure to respect patient rights.

When a complaint is filed it must include the following information:

- Patient Information: Patient Name, Date of Birth, Patient ID, Patient Phone
- Provider Information: Provider Name, Address, Phone Number, Fax Number
- Complaint information: Date & Time of Submission, Submitters Name, Phone & Fax along with a detailed description or the nature of the complaint

PharmaForce has up to 30 days to investigate and resolve the complaint/grievance, the provider will be notified via email or fax. A grievance is not entitled to an appeal as all decisions are considered final.

Cultural Competency

While providing patients with counseling and/or consultation regarding treatment options (including the option of no treatment), all information shall be delivered in a culturally competent manner.

Nondiscrimination

Pharmacies cannot discriminate against a patient based on age, race, color, ethnic group, national origin, gender, religion, disability, medical condition, political convictions, sexual orientation, or marital/family status. Pharmacies are required to provide pharmacy services related to covered items to all eligible patients in accordance with applicable law unless professional judgment states otherwise.

Professional Judgement

Pharmacy services are required to be dispensed under the direct supervision of a licensed pharmacist and according to prescriber instructions in accordance with applicable law. The pharmacist must always exercise professional judgement in providing pharmacy services to patients. The pharmacist may refuse to provide pharmacy services to a patient based on their clinical professional judgement.





Update information with NCPDP

PharmaForce will change the participating pharmacy address, phone number, and pharmacy chain/PSAO affiliation based on the NCPDP updates received monthly. At this time, only one NCPDP affiliation is supported.

It is the pharmacy's responsibility to contact NCPDP when information changes to ensure data integrity. In the event information is missing or conflicting from the pharmacy and information on file with NCPDP, PharmaForce will utilize the information on file with NCPDP as the source of truth.

National Plan and Provider Enrollment System (NPPES) Updates

Pharmacies are strongly encouraged to update their information, including all taxonomy codes on the National Plan and Provider Enrollment System (NPPES). The updates can be made at the following website: <https://nppes.cms.hhs.gov>

The information on NPPES, including the pharmacy's taxonomy information, may be used for network and contract validation by administrators, clients, and government agencies such as the Center for Medicare and Medicaid Services (CMS).

Disputed Claims

Participating pharmacies are required to review their invoices or remittance advice when received to verify accuracy. If the pharmacy wishes to dispute a claim payment they must notify the PharmaForce Pharmacy Network team at PharmacyNetwork@thepharmaforce.com within the specific timeframe outlined in the Pharmacy Service Agreement, if not specific, within thirty (30) calendar days.

- The dispute must be explained in sufficient detail on why the claim is being disputed for payment or adjustment. Pharmacies can submit all necessary documentation which includes the Explanation of Payment (EOP) for consideration, of additional reimbursement.

Applicable to underpayment: Any claim payment not disputed after thirty (30) days of the pharmacies receipt of invoice is considered to be confirmed as accurate by the pharmacy. PharmaForce will only investigate the invoice or remittance advice for the claim dispute or adjustment only if notified in the timeframe listed above. Failure to notify PharmaForce by the required timeframe shall make all claim determinations and their associated payments final.





Fraud, Waste & Abuse

Pharmacists are required to exercise professional judgement when it comes to the validity of prescription orders dispensed. Pharmacists are not required by law to dispense medication if they suspect that the ordered prescription is not valid. Participating pharmacies will use their best efforts to adhere to all applicable state and federal laws.

- Fraud is an intentional act of disinformation, fabrication, or cover up in order to gain something of value. Fraud includes any act that constitutes fraud under applicable federal or state law (18 United States Code §1347).
- Waste is overutilization of practices, other services, and misuse of resources resulting in unnecessary costs.
- Abuse includes practices that are inconsistent with acceptable or medical practices that may directly or indirectly cause financial loss.

Participating pharmacies are required to have staff go through initial and subsequent annual training for FWA. Pharmacy staff training documentation may be requested by PharmaForce during an audit or through our routine pharmacy credentialing processes.

Contact Information

Phone	(929) 352-1668
Email	RxFWA@thepharmaforce.com

Advertising and Promotions

Participating pharmacies must not use trademarks, symbols, words, or a service marks PharmaForce uses in any advertising or promotional materials without prior written consent from PharmaForce. Upon termination the participating pharmacy must immediately discontinue any and all usage of materials that were approved via written consent.

PharmaForce may list participating pharmacies by name, address, and telephone number for each location in directories or any advertisements such as a brochures, publications, website network search tool, and/or use by PharmaForce, payers, and eligible person(s).

Patient Rights & Responsibilities

PharmaForce is committed to our patients and to providing them the best pharmacy services and benefits possible. PharmaForce and any participating pharmacy may not discriminate



against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis prohibited by law. Patients are encouraged to read and understand their benefits.

Patients have the right to:

- Receive information about PharmaForce, our services and your rights and responsibility
- Be treated with respect and dignity
- Have the right to privacy and access any of your personal health information (PHI)
- Be an active participant with your health care providers when making decisions about your health
- Access prescription services without discrimination
- Have information about your health and personal drug use protected. This right does not prevent the use of your information for healthcare purposes. Healthcare purposes are defined as quality improvement, disease management, report claims adjudication, and compliance programs.

Patients have the responsibility to:

- Read the member handbook and be familiar with your prescription benefit, this includes knowing the limits and rules of your plan benefit
- Review and understand the formulary so you are able to discuss safe and cost-effective medications with your health care prescriber
- Understand your health conditions and be proactive in your own treatment. If you do not understand your condition or treatment plan provided by your prescriber, we recommend you discuss this with your health care prescriber
- Ask questions and learn about your drug therapy, this includes limitations and risk associated with the medication(s)
- Inform PharmaForce if you have any changes in your eligibility for coverage. This could include getting married, having additional insurance coverage, and so forth.
- Provide your health care providers the necessary information to determine the appropriate drug therapy for you. Necessary information includes health status, lifestyle, and current/past medications
- Adjust lifestyle habits that are safe and effective with your drug therapy regime. This may include limiting smoking, alcohol use and changes in diet.

- Adhere to any financial obligations, administrative and operational procedures of your pharmacy benefit
- Report any fraud or misbehavior to PharmaForce

Version Information

Version	Date	Notes
1.0	7/15/2022	Provider Manual effective July 15, 2022
1.1	1/1/2023	Updated year from 2022 to 2023
1.2	11/11/2023	Updated phone number from 717-902-9169 to 833-379-1643
1.3	11/28/2023	Updated Payer Sheet and updated year from 2023-2024
1.4	11/29/2023	Addition of TN wholesaler reporting for claims processing
1.5	12/19/2023	Updated Pharmacy Network Fax Number to 866-825-0007 and updated Payer Sheet
1.6	2/19/2024	Updated RxHelpDesk email
1.7	12/9/2024	Updated Payer Sheet and updated year from 2024 to 2025
1.8	9/04/2025	Updated fax number for Pharmacy Reimbursement Appeals from 814-778-0707 to 1-866-825-0007 Updated formatting. Updated Payer Sheet to latest version.
1.9	9/19/25	Updated site URL to https://pbm.thepharmaforce.com/pharmacies
2.0	10/23/2025	Updated to include compound section
2.1	11/11/2025	Update compound information
2.2	12/16/2025	Updated year from 2025 to 2026. Updated Payer Sheet.



Appendix A: Payer Sheet

General Information

Payer Name: PharmaForce PBM	Effective Date: 6/1/2022
Processor: PharmaForce	NCPDP Version/Release: D.Ø
NCPDP External Code List Version Date: 10/2019	Payer Sheet Version: 1.16
Pharmacy Relations Contact Information Phone: 1-833-379-1643, Hours M-F: 8 a.m. - 8 p.m. EST, S-S: 9 a.m. - 6 p.m. EST Email: pharmacynetwork@thepharmaforce.com	

Pharmacy Processing

Plan Name/Group Name	BIN	PCN	Help Desk Number
PharmaForce	024269	PFORCE PFCOMM	1-833-379-1643 M-F: 8 a.m. - 8 p.m. EST S-S: 9 a.m. - 6 p.m. EST
	As noted on Insurance Card		

Payer Legend

M	Mandatory as defined by NPDP
R	Required as defined by the processor
RW	Situational as defined by Plan





Billing Transaction/Segments and Fields

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
101-A1	BIN NUMBER	024269	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	NCPDP v D0
103-A3	TRANSACTION CODE	B1	M	Claim billing transaction. Note that rebill (B3) is not support
104-A4	PROCESSOR CONTROL NUMBER	PFORCE	R	Use value printed on the ID Card
109-A9	TRANSACTION COUNT	01 - 04	M	Only accept Value 01
202-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	01 = National Provider ID (NPI). Only NPI is accepted
201-B1	SERVICE PROVIDER ID	NPI	M	NPI assigned to the dispensing pharmacy
401-D1	DATE OF SERVICE		M	YYYYMMDD
110-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	04	M	Insurance Segment
302-C2	CARDHOLDER ID		M	
312-CC	CARDHOLDER FIRST NAME		R	Required when necessary for state/federal/regulatory agency programs
313-CD	CARDHOLDER LAST NAME		R	Required when necessary for state/federal/regulatory agency programs
301-C1	GROUP ID		R	As printed on the ID card
303 - C3	PERSON CODE	00 - 99	R	
306-C6	PATIENT RELATIONSHIP CODE	1 - Cardholder 2 - Spouse 3 - Child 4 - Other 5 - Student 6 - Disabled Dependent	R	





Patient Segment: Required

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø1	M	Insurance Segment
3Ø4-C4	DATE OF BIRTH		R	YYYYMMDD
3Ø5-C5	PATIENT GENDER CODE	1-Male 2-Female	R	1-Male 2-Female
31Ø-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		RW	Required for some federal programs, when submitting Sales Tax, or Emergency Override code
323-CN	PATIENT CITY ADDRESS		RW	Required for some federal programs, when submitting Sales Tax, or Emergency Override code
324-CO	PATIENT STATE / PROVINCE ADDRESS		RW	Required for some federal programs, when submitting Sales Tax, or Emergency Override code
325-CP	PATIENT ZIP/POSTAL ZONE		RW	Required for some federal programs, when submitting Sales Tax, or Emergency Override code
326-CQ	PATIENT PHONE NUMBER		RW	
3Ø7-C7	PLACE OF SERVICE	01-Pharmacy 12-Home 13-Assisted Living 31-Skilled Nursing Facility 32-Nursing Facility	RW	Required for home infusion and LTC patients. Accepted values listed
335-2C	PREGNANCY INDICATOR		RW	Required for some federal programs
35Ø-HN	PATIENT E-MAIL ADDRESS		RW	
384-4X	PATIENT RESIDENCE	1-Home 2-Skilled Nursing Facility 3-Nursing Facility 4-Assisted Living Facility 11-Hospice	RW	Required when the Patient Residence and Pharmacy Service Type submitted for Long Term Care, Assisted Living or Home Infusion Processing





Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø7	M	Insurance Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	1 = Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	Rx Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	Format: MMMMMDDDDPP MMMMM=Manufactured assigned number DDDD=Drug ID PP=Package Size
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	Ø1 = Not a Compound Ø2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	0-9	RW	0 = No product selection indicated 1 = Prescriber DAW 2 = Patient selection 3 = Pharmacist selection 4 = No generic available at pharmacy 5 = Brand dispensed as generic 6 = Override 7 = Brand mandated by law 8 = No generic in marketplace 9 = Plan requested brand
414-DE	DATE PRESCRIPTION WRITTEN		R	YYYYMMDD
415-DF	NUMBER OF REFILLS AUTHORIZED		RW	Required if necessary for plan benefit administration
419-DJ	PRESCRIPTION ORIGIN CODE	1 – Written 2 – Telephone 3 – Electronic 4 – Facsimile 5 – Pharmacy	RW	Required when necessary for plan benefit administration
46Ø-ET	QUANTITY PRESCRIBED		RW	Required when the claim is for schedule II drug





Claim Segment: Mandatory continued

Field #	NCPDP Field Name	Value	Req	Comment
308-C8	OTHER COVERAGE CODE	0=Not specified by patient 1=No other coverage 8=Claim is billing for patient financial responsibility only	R	Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers.
446-EB	ORIGINAL PRESCRIBED QUANTITY		RW	
600-28	UNIT OF MEASURE	EA (Each) GM (Grams) ML (Milliliters)	R	
147-U7	PHARMACY SERVICE TYPE	01 – Community/Retail Pharmacy Services 05 – Long Term Care Pharmacy Services 06 – Mail Order Pharmacy Services 08 – Specialty Pharmacy	R	





Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	11	M	Insurance Segment
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
438-E3	INCENTIVE AMOUNT SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation. Required when submitting for a Vaccination
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	Required if its value has an effect on the Gross Amount Due (430-DU) calculation.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	Required when provider is claiming sales tax Required when submitting Percentage Sales Tax Rate submitted (483-HE) and Percentage Sales Tax Basis Submitted (484-JE)
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	Required when provider is claiming sales tax Required when submitting Percentage Sales Tax amount Submitted (483-GE) and Percentage Sales Tax Basis Submitted (484-JE)
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	Required when provider is claiming sales tax Required when submitting Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE)
426-DQ	USUAL AND CUSTOMARY CHARGE		R	
430-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		RW	Required if needed for receiver claim/encounter adjudication





Prescriber Segment: Required

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø3	M	Insurance Segment
466-EZ	PRESCRIBER ID QUALIFIER	Ø1 = National Provider Identifier (NPI)	R	
411-DB	PRESCRIBER ID	National Provider Identifier (NPI)	R	

Coordination of Benefits/Other Payments Segment-Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø5	M	Insurance Segment
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT		M	Maximum Count of 3.
338-5C	OTHER PAYER COVERAGE TYPE	Ø1-Primary Ø2-Secondary Ø3-Tertiary	M	Ø1-Primary-First Ø2-Secondary-Second Ø3-Tertiary-Third
339-6C	OTHER PAYER ID QUALIFIER	Ø3 = Issuer Identification Number (IIN) also known as BIN	RW	Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		RW	Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	OTHER PAYER DATE		RW	YYYYMMDD
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	6-Patient Responsibility	RW	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	Only accepting a value of 6 Required if necessary for patient financial responsibility only billing.

The COB segment and all required fields must be sent if the Other Coverage Code (3Ø8-C8) field submitted in the claim segment is 8. Value 8 is billing for patient financial responsibility only; fields 353-NR, 351-NP and 352-NQ are required and must have values entered.





DUR/PPS Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø8	M	Insurance Segment
473-E7	DUR/PPS CODE COUNTER	Maximum count of 9	RW	Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE	DD	RW	DD = Drug – Drug
44Ø -E5	PROFESSIONAL SERVICE CODE		RW	
441-E6	RESULT OF SERVICE CODE		RW	

Compound Segment: Situational

Required when multi-ingredient compound is submitted

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	1Ø	M	Insurance Segment
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	01- Capsule 02- Ointment 03- Cream 04- Suppositor y 05- Powder 06- Emulsion 07- Liquid 10 – Tablet 11 – Solution 12 – Suspension 13 – Lotion 14 – Shampoo 15 – Elixir 16 – Syrup 17 – Lozenge 18 – Enema	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1- Each 2- Grams 08- Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = National Drug Code DC	M	Only accepting Ø3 = National Drug Code DC
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST		R	Required if needed for receiver claim determination when multiple products are billed.





Compound Segment: Situational continued

Field #	NCPDP Field Name	Value	Req	Comment
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	00-Default 01-AWP 02-Local Wholesaler 03-Direct 04-EAC (Estimated Acquisition Cost) 05-Acquisition 06-MAC (Maximum Allowable Cost) 07-Usual & Customary 08-340B/Disproportionate Share Pricing/Public Health Service 09-Other 10-ASP (Average Sales Price) 11-AMP (Average Manufacturer Price) 12- WAC (Wholesaler Acquisition Cost) 13-Special Patient Pricing 14-Cost Basis on unreportable quantities 15-Free Product or no associated cost 16-Nominal price 17-Federal Supply Schedule	R	Required if needed for receiver claim determination when multiple products are billed.
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 1Ø.	RW	Required when Compound Ingredient Modifier Code (363-2H) is sent.
363-2H	COMPOUND INGREDIENT MODIFIER CODE		RW	Required if necessary for state/federal/regulatory agency programs.





Clinical Segment: Situational

Required when requested by Plan

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	13	M	Insurance Segment
491-VE	DIAGNOSIS CODE COUNT	Maximum of 5	RW	Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø2- International Classification of Diseases (ICD10)	RW	Required if Diagnosis Code (424-DO) is used
424-DO	DIAGNOSIS CODE		RW	Required if this information can be used in place of prior authorization.





Response

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

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
102-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
103-A3	TRANSACTION CODE	B1	M	Same value as in request billing. B1 transaction
109-A9	TRANSACTION COUNT		M	Same value that is in request
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER		M	Same value as in request
201-B1	SERVICE PROVIDER ID		M	Same value as in request
401-D1	DATE OF SERVICE		M	Same value as in request-YYYYMMDD

Response Message Segment: Situation

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Insurance Segment
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

Response Insurance Segment: Situational:

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	25	M	Insurance Segment
301-C1	GROUP ID		R	Same value that is in request
302-C2	CARDHOLDER ID		M	Same value that is in request
524-FO	PLAN ID		RW	Required if needed to identify the actual plan parameters, benefit, or coverage criteria
545-2F	NETWORKING REIMBURSEMENT ID		RW	Required if needed to identify the network for the covered member.





Response Coordination of Benefits/Other Payers Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	28	S	Insurance Segment
335-NT	OTHER PAYER ID COUNT		M	Maximum Value submitted in 338-5C
338-5C	OTHER PAYER COVERAGE TYPE	Ø1-Primary Ø2-Secondary Ø3-Tertiary	S	
339-6C	OTHER PAYER ID QUALIFER	Ø3 = Issuer Identification Number (IIN) also known as BIN	S	Required if Other Payer ID 340-7C is used
340-7C	OTHER PAYER ID		S	Required if other insurance information is available for coordination of benefits.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER		NR	
356-NU	OTHER PAYER CARDHOLDER ID		NR	
992-MJ	OTHER PAYER GROUP ID		NR	
142-UV	OTHER PAYER PERSON CODE		NR	
127-UB	OTHER PAYER HELP DESK PHONE NUMBER		NR	
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE		NR	
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE		NR	
145-UY	OTHER PAYER BENEFIT TERMINATION DATE		NR	





Response Patient Segment: Required

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	29	M	Insurance Segment
310-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
304-C4	DATE OF BIRTH		R	YYYYMMDD

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	21	M	Insurance Segment
112-AN	TRANSACTION RESPONSE STATUS		M	P=Paid D=Duplicate of Paid
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/P BM	RW	Required when Help Desk Phone Number (550-8F) is used
550-8F	HELP DESK PHONE NUMBER	833-379-1643	RW	Required when needed to provide a support telephone number to the receiver

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	22	M	Insurance Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	1 = RxBilling
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	RX Number





Response Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	23	M	Insurance Segment
505-F5	PATIENT PAY AMOUNT		R	
506-F6	INGREDIENT COST PAID		R	
507-F7	DISPENSING FEE PAID		RW	Required when this value is used to arrive at the final reimbursement.
558-AW	FLAT SALES TAX AMOUNT PAID		RW	Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement.
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	Tax dollar amount paid
560-AY	PERCENTAGE SALES TAX RATE PAID		RW	Rate used to calculate Percentage Sales Amount Paid (559-AX)
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	Code indicating basis of dollars used in calculating tax in the final paid claim
521-FL	INCENTIVE AMOUNT PAID		RW	Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø).
509-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	9 - Used to indicate when reimbursement is based upon the actual cost of the item 14-Patient Responsibility Amount	RW	Required if Ingredient Cost Paid (506-F6) is greater than zero (Ø).





Respond DUR/PPS Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	24	M	Insurance Segment
567-J6	DUR/PPS RESPONSE COUNTER CODE	Maximum count of 9	RW	Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE	DD	RW	
528-FS	CLINICAL SIGNIFICANCE CODE	1: Major 2: Moderate 3: Minor 9: Undetermined	RW	Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR	1: Your Pharmacy 2: Other Pharmacy in Same Chain 3: Other Pharmacy	RW	Required if needed to supply additional information for the utilization conflict.
53-FU	PREVIOUS DATE OF FILL	CCYYMMDD	RW	Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	Required if Previous Date Of Fill (530-FU) is used.
532-FW	DATABASE INDICATOR	1: First DataBank 2: Medi-Span Product Line	RW	Required if needed to supply additional information for the utilization conflict.
533-RX	OTHER PRESCRIBER INDICATOR	0: Not specific 1: Same prescriber 2: other prescriber	RW	Required if needed to supply additional information for the utilization conflict.
544-FYI	DUR FREE TEXT MESSAGE		RW	Required if needed to supply additional information for the utilization conflict.





Claim Billing Accepted/Reject Response

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
102-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
103-A3	TRANSACTION CODE		M	Same value as in request billing. B1 transaction
109-A9	TRANSACTION COUNT		M	Same value that is in request
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER		M	Same value as in request
201-B1	SERVICE PROVIDER ID		M	Same value as in request
401-D1	DATE OF SERVICE		M	Same value as in request- YYYYMMDD

Response Message Segment: Situation

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Insurance Segment
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

Response Insurance Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	25	M	Insurance Segment
301-C1	GROUP ID		R	Same value that is in request
524-FO	PLAN ID		RW	
302-C2	CARDHOLDER ID		M	Same value that is in request

Response Patient Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	29	M	Insurance Segment
310-CA	PATIENT FIRST NAME		R	
311-CB	PATIENT LAST NAME		R	
304-C4	DATE OF BIRTH		R	YYYYMMDD





Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	21	M	Insurance Segment
112-AN	TRANSACTION RESPONSE STATUS	R	M	R=Reject
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Rejection Code	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Required when a repeating field is in error, to identify repeating field occurrence
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	RW	Required when Help Desk Phone Number (550-8F) is used
550-8F	HELP DESK PHONE NUMBER	833-379-1643	RW	Required when needed to provide a support telephone number to the receiver

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	22	M	Insurance Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	1 = RxBilling
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	RX Number





Claim Billing Rejected/Rejected Response Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
102-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
103-A3	TRANSACTION CODE	B1	M	Same value as in request billing. B1 transaction
109-A9	TRANSACTION COUNT		M	Same value that is in request
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER		M	Same value as in request
201-B1	SERVICE PROVIDER ID		M	Same value as in request
401-D1	DATE OF SERVICE		M	Same value as in request- YYYYMMDD

Response Message Segment: Situation

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Insurance Segment
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	21	M	Insurance Segment
112-AN	TRANSACTION RESPONSE STATUS	R	M	R=Reject
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Rejection Code	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Required when a repeating field is in error, to identify repeating field occurrence
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required when Help Desk Phone Number (550-8F) is used
550-8F	HELP DESK PHONE NUMBER	833-379-1643	RW	Required when needed to provide a support telephone number to the receiver





Reversal

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
1Ø1-A1	BIN NUMBER	024269	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER		R	Same value in the request billing
1Ø9-A9	TRANSACTION COUNT	Ø1 – Ø4	M	Up to four billing reversal transactions (B2) per transmission
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 =NPI	M	Ø1 = National Provider ID (NPI). Only NPI is accepted
2Ø1-B1	SERVICE PROVIDER ID	NPI	M	NPI assigned to the dispensing pharmacy
4Ø1-D1	DATE OF SERVICE		M	YYYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID		M	

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID		R	

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø7	M	Insurance Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	1 = Rx Billing
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	Rx Number. Same value as in request billing
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code (NDC)	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	Same value as in request billing Format: MMMMMDDDDPP MMMMM=Manufactured assigned number DDDD=Drug ID PP=Package Size
442-E7	QUANTITY DISPENSED		R	Same value as in request billing
4Ø3-D3	FILL NUMBER		R	Same value as in request billing





Claim Reversal Accepted/Approved Response Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
102-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER		R	Same value in the request billing
109-A9	TRANSACTION COUNT		M	Same value as in request
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 =NPI	M	Same value as in request
201-B1	SERVICE PROVIDER ID	NPI	M	Same value as in request
401-D1	DATE OF SERVICE		M	Same value as in request- YYYYMMDD

Response Message Segment: Situation

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Insurance Segment
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	21	M	Insurance Segment
112-AN	TRANSACTION RESPONSE STATUS	A=Approved S=Duplicate of Approved	M	A=Approved S=Duplicate of Approved
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/ PBM	RW	Required when Help Desk Phone Number (55Ø-8F) is used
55Ø-8F	HELP DESK PHONE NUMBER	833-379-1643	RW	Required when needed to provide a support telephone number to the receiver

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	22	M	Insurance Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	1 = RxBilling
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	RX Number





Claim Reversal Accepted/Rejected Response

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
102-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER		R	Same value in the request billing
109-A9	TRANSACTION COUNT		M	Same value as in request
501-F1	HEADER RESPONSE STATUS	A = Accepted	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 =NPI	M	Same value as in request
201-B1	SERVICE PROVIDER ID	NPI	M	Same value as in request
401-D1	DATE OF SERVICE		M	Same value as in request- YYYYMMDD

Response Message Segment: Situation

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Insurance Segment
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	21	M	Insurance Segment
112-AN	TRANSACTION RESPONSE STATUS	R	M	R=Reject
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Rejection Code	R	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required when Help Desk Phone Number (550-8F) is used
550-8F	HELP DESK PHONE NUMBER	833-379-1643	RW	Required when needed to provide a support telephone number to the receiver

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	22	M	Insurance Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1	M	1 = RxBilling
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	RX Number





Claim Reversal Reject/Rejected Response

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
102-A2	VERSION/RELEASE NUMBER	DØ	M	NCPDP v DØ
103-A3	TRANSACTION CODE	B2	M	
104-A4	PROCESSOR CONTROL NUMBER		R	Same value in the request billing
109-A9	TRANSACTION COUNT		M	Same value as in request
501-F1	HEADER RESPONSE STATUS	R = Rejected	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Ø1 =NPI	M	Same value as in request
201-B1	SERVICE PROVIDER ID	NPI	M	Same value as in request
401-D1	DATE OF SERVICE		M	Same value as in request-YYYYMMDD

Response Message Segment: Situation

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Insurance Segment
504-F4	MESSAGE		RW	Required if text is needed for clarification or detail.

Response Status Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	21	M	Insurance Segment
112-AN	TRANSACTION RESPONSE STATUS	R	M	R=Reject
510-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE	NCPDP Rejection Code	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	Required when a repeating field is in error, to identify repeating field occurrence
549-7F	HELP DESK PHONE NUMBER QUALIFIER	Ø3 = Processor/PBM	RW	Required when Help Desk Phone Number (550-8F) is used
550-8F	HELP DESK PHONE NUMBER	833-379-1643	RW	Required when needed to provide a support telephone number to the receiver





Version Information

Version	Date	Notes
1.0	2/23/2022	Payer Sheet effective April 1, 2022
1.1	2/25/2022	Updated helpdesk phone number.
1.2	3/29/2022	Added COB and updated Relationship Code to accept 1 from 01
1.2	4/6/2022	Made Cardholder First Name & Last Name required
1.2	4/21/2022	Added Help Desk Email to contact information
1.2	4/22/2022	Removed "Pharmacy Provider Segment". Revised "Clinical Segment" to include "required when requested by plan"
1.3	6/15/2022	522-FM-added 9 for non-COB claims, continue to use 14 to for COB claims
1.4	9/1/2022	Added Field 491-VE: Diagnosis Code Count
1.4	9/14/2022	Added 08-Specialty to field 147-U7. Added Sales Tax Appendix
1.4	10/12/2022	426-DQ was updated to Required
1.5	1/1/2023	Updated date from 2022 to 2023
1.6	7/6/2023	Updated help desk timeframes
1.7	9/19/2023	Updated to include 438-E3 in the claim segment and 521-FL in the response pricing segment.
1.7	10/3/2023	Added Compound Segment 11-AM 1Ø. Updated Insurance Response Segment to include 524-FO and 545-2F
1.8	11/13/2023	Updated phone number from 7147-902-9169 to 833-379-1643
1.9	11/28/2023	Updated date from 2023 to 2024
1.10	12/14/2023	Updated Relationship Code and added Person Code
1.11	10/1/2024	Updated Hours
1.12	12/5/2024	Updated date from 2024 to 2025 and separated out RxSavingsCard (Cash Card) Payer Sheet and Self-Employed (Commercial) Payer Sheet
1.13	1/21/2025	Included field 337-4C for COB and COB Response section
1.14	4/3/2025	Added DUR segment, DUR Response and Added Route of Administration for use of Compounds
1.15	8/12/2025	Updated formatting. No content updates.
1.16	12/16/2025	Added new commercial PCN PFCOMM and added notation to PCNs as noted on Insurance Card





Payer Sheet Appendix A: Sales Tax

Pharmacies submitting claims with sales tax are required to submit the detailed values outlined below.

Pharmacies submitting the service type of 06 - Mail Order Pharmacy Services or 08 - Specialty Care Pharmacy Services will need to indicate where the order is being shipped to the patient by ensuring the required fields are transmitted. Value 324-CO, Patient/State Province Address should be linked to the actual destination address of the patient where the medication will be delivered.

If the actual destination address is not accessible, the patient demographics address may be submitted. Any other pharmacy service type being processed is required to submit the Pharmacy Service Type code to be reimbursed for sales tax properly.

Required fields for Mail Order & Specialty Service Type

NCPDP Segment	NCPDP Field Number	NCPDP Field Name	Value
111-AM Ø1 - Patient Segment	322-CM	Patient Street Address	
111-AM Ø1 - Patient Segment	323-CN	Patient City Address	
111-AM Ø1 - Patient Segment	324-CO	Patient State/Province Address	
111-AM Ø1 - Patient Segment	325-CP	Patient Zip/Postal Zone	
111-AM Ø1 - Patient Segment	481-HA	Flat Sales Tax Amount Submitted	
111-AM Ø7 - Claim Segment	147-U7	Pharmacy Service Type	06 - Mail Order 08 - Specialty
111-AM 11 Pricing Segment	482-GE	Percentage Sales Tax Amount Submitted	
111-AM 11 Pricing Segment	483-HE	Percentage Sales Tax Rate Submitted	
111-AM 11 Pricing Segment	484-JE	Percentage Sales Tax Basis Submitted	

Required Fields for Tax on Pharmacy Service Type (except for Mail Order & Specialty)

NCPDP Segment	NCPDP Field Number	NCPDP Field Name	Value
111-AM Ø1 - Patient Segment	322-CM	Patient Street Address	
111-AM Ø1 - Patient Segment	323-CN	Patient City Address	
111-AM Ø1 - Patient Segment	324-CO	Patient State/Province Address	
111-AM Ø1 - Patient Segment	325-CP	Patient Zip/Postal Zone	
111-AM Ø1 - Patient Segment	481-HA	Flat Sales Tax Amount Submitted	
111-AM 11 Pricing Segment	482-GE	Percentage Sales Tax Amount Submitted	
111-AM 11 Pricing Segment	483-HE	Percentage Sales Tax Rate Submitted	
111-AM 11 Pricing Segment	484-JE	Percentage Sales Tax Basis Submitted	

