NCPDP EMERGENCY PREPAREDNESS INFORMATION

VERSION 1.4

This document provides resource information for the pharmacy industry for a declared emergency.

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1. INTRODUCTION

This document provides guidance to the pharmacy industry for resources available during a declared emergency. The intended audience is healthcare industry providers who would need resource information for eligibility and claims processing affecting displaced individuals. The document will be updated as new information is available.

During the Katrina and Rita hurricanes, the pharmacy industry (as well as other participants) came together to offer products, services, and care to displaced individuals. During the 2006 NCPDP Annual Conference, an Educational Session entitled "A Panel Discussion on Disaster Preparedness: Lessons Learned from Mother Nature" was held. While there were many areas that needed improvement in reacting to a disaster based on this panel's experience, and there are many aspects to a disaster, it was suggested that there were some actions the NCPDP community could provide for future disasters. The NCPDP Emergency Preparedness Committee was formed by the NCPDP Board of Trustees. The Committee began meeting to determine what aspects of preparation for a disaster would be within its purview. This document has been prepared by the Committee to assist in information sharing and processing. NCPDP is a standards development organization, which brings together many participants in the pharmacy services sector, to help find solutions to business problems.

This document outlines processes that must be daily occurrences rather than the "break glass" situations. Processes and procedures that are set up for use as part of daily routines could be invoked at a moment's notice, and some aspects of the emergency would not require new training.

For example, the payers/pharmacy benefit managers would have emergency criteria established within the "usual" plan establishment functions the industry performs routinely each day. The setup of plan parameters and routing information within a pharmacy system is a routine function today. By setting up the plan parameters and routing information for emergency situations now as part of normal procedures, this information would be available for use soon after the disaster was declared. Enrollment files that are updated routinely are therefore accessible at a declared disaster moment. Medication history information is available routinely to providers, so the functions can be used in an emergency as well. This document will provide resource information on some of these aspects.

If you have any questions regarding the availability or content of this document, see ncpdp.org, or contact the Council office at 480-477-1000 or via email at ncpdp@ncpdp.org.

2. WHAT TRIGGERS AN EMERGENCY RESPONSE

2.1 STATE AND LOCAL DECLARED EMERGENCIES

1. Based on a request from State or Local authorities, Healthcare Ready may activate Rx Open. Based on impending chances of a disaster, Healthcare Ready may activate Rx Open. For details refer to Rx Open.
2. Pharmacies, Payers and Prescribers should review this document to ensure they are enabled to assist in industry notification and processing of claims. Refer to What do I need to do.

2.2 FEDERAL DECLARED EMERGENCIES

1. In addition to State and Local declared disasters, the Federal Government may declare a federal disaster. After a federal disaster has been declared, the U.S. Department of Health and Human Services' (HHS) and/or Federal Emergency Management Agency (FEMA) may make a decision to activate the Emergency Prescription Assistance Program (EPAP) based on the potential risk for patients' inability to obtain their medication.

3. WHAT DO I NEED TO DO?

During a disaster, it is recognized that many important steps must take place. This section provides a high level list of items covered in this document to assist in industry notification and processing of claims.

3.1 PHARMACIES/AUTHORIZED REPRESENTATIVE OF PHARMACIES

An authorized representative of a pharmacy (e.g., the actual pharmacy owner, a representative of the chain or network headquarters) should have information contained in this document readily available at the time of disaster and be able to properly communicate this information where needed.

3.1.1 DURING EMERGENCY

See Rx Open.

3.1.2 ONGOING

1. Verify payer/plan emergency information is loaded into pharmacy software and available for use.
2. If participating in a business relationship where medication history information is contributed regularly, provide current information timely.
3. If participating in a business relationship where medication history information is available upon a disaster, verify processes and procedures are in place and executable.
4. To receive timely situational awareness updates in the event of a disaster, ensure contact information is current with the Assistant Secretary for Preparedness Response (ASPR) Critical Infrastructure Protection for the Healthcare and Public Health Sectors (CIP) and Prescription Medication Preparedness Initiative (PMPI) programs. See Appendix B.

3.1.3 PHARMACISTS PRESCRIBING

Emergency Protocols

All states have procedures in place that address a pharmacist's ability to dispense an emergency supply of maintenance medication per a protocol outlined by the State Board of Pharmacy. All pharmacists should be familiar with their individual state's emergency procedures. For specific state allowances, refer to this website: healthcareready.org/blog/state-emergency-refills.

- If emergency state protocols permit pharmacies to prescribe on an extraordinary basis—and those pharmacists have no National Provider Identifier (NPI) because they do not have pre-established authority to prescribe—then CMS may be able to accept a Type II NPI as the prescriber on Medicare Part D Prescription Drug Events (PDEs).
- Commercial plans should refer to their provider manual. It is recommended that all pharmacists obtain their own NPI.
- Pharmacists without prescribing authority will need to use the pharmacy NPI when prescribing in an emergency situation.

3.1.4 EPRESCRIBING RENEWAL REQUESTS

- If a patient loses a non-refillable prescription (i.e., a controlled substance) during a disaster, a Renewal Request should be sent to the prescriber. The request should include a message in the notes field (Dispense Loop) explaining the situation and how many days of medication were lost.
- When a pharmacy needs to communicate an urgent refill request due to a disaster situation, a Renewal Request should be sent to the prescriber. The request should include a message in the notes field (Dispense Loop) explaining the urgency due to the disaster situation. In the next version of the SCRIPT Standard an urgency indicator will be used.

3.2 PAYERS

3.2.1 DURING EMERGENCY

1. See Rx Open.

3.2.2 ONGOING

1. Verify payer/plan sheets for processing requirements for a disaster are up to date and available to industry participants.
2. Current information should be provided if participating in a business relationship where medication history information is regularly contributed.
3. To receive timely situational awareness updates in the event of a disaster, ensure contact information is current with the Assistant Secretary for Preparedness Response (ASPR) Critical Infrastructure Protection for the Healthcare and Public Health Sectors (CIP) and Prescription Medication Preparedness Initiative (PMPI) programs. See Appendix B.

3.3 PRESCRIBERS

3.3.1 DURING EMERGENCY

1. See Rx Open.
2. EHR vendors and pharmacies currently prescribing electronically would continue to do so if their systems are up and available in an emergency situation.
3. In the event that one of the components (EHR system, E-Prescribing network, PBM system, Pharmacy system) is down or unavailable, the prescriber would default to writing paper prescriptions, following all state-specific guidelines.
4. Prior to sending any prescription (electronic or paper), it is recommended the prescriber verify operational status of the intended pharmacy. If the prescriber still has internet access during the emergency timeframe, this may be accomplished by accessing healthcareready.org (Refer to section 8.1).

3.3.2 ONGOING

Current information should be provided if participating in a business relationship where medication history information is regularly available.

3.3.3 EPRESCRIBING RENEWAL REQUESTS

- If a patient loses a non-refillable prescription (i.e., a controlled substance) during a disaster, a Renewal Request will be sent by the pharmacy. The request will include a message in the notes field (Dispense

Loop) explaining the disaster situation and the number of days of medication being requested because the medication was lost.

- In the next version of the SCRIPT Standard an urgency indicator will be used. When a pharmacy needs to communicate an urgent refill request to the prescriber due to a disaster situation, the pharmacy will send a Renewal Request. The request will include a message in the notes field (Dispense Loop) explaining the urgency due to the disaster situation.

3.4 SWITCHES/CLEARINGHOUSES REPORTING TO HEALTHCARE READY

Healthcare Ready is committed to working together with local, state and federal officials as well as the private sector and volunteer organizations to help support the continued delivery of healthcare and healthcare supplies (including medicines) to people who need them in the event of such an emergency – whether it is caused by a natural disaster, terrorist incident or health emergency such as a pandemic.

Industry switches/clearinghouses have developed a process for reporting active pharmacies to the Healthcare Ready tool Rx Open. In some cases, the pharmacy needs to authorize its switching vendor to send active claim status to Healthcare Ready. Pharmacies want to make sure they have completed this authorization for their pharmacies to display as active during an emergency in order for patients and healthcare providers to find you. If you have not completed the authorization form and obtained notification, contact ContactUs@healthcareready.org to self-report.

3.4.1 RX OPEN

When activated, Rx Open (healthcareready.org/rxopen), formerly called the Pharmacy Status Reporting Tool, is a way for the public to locate nearby open pharmacies in a disaster-impacted area so they can gain access to needed medicines. This powerful Google map marks the location and operating status (open, closed or unknown) of those pharmacies. It also maps open Red Cross shelters.

Healthcare Ready only activates Rx Open at the request of government officials or following some federal disaster declarations. Rx Open provides the tool specifically for the impacted area and updates the tool daily until the crisis has stabilized. A "disaster" may include, but is not limited to: a severe natural disaster (such as a hurricane or widespread ice or tornado-generating storm) or an incident that affects infrastructure in a wide geographical area (such as a terrorist attack or pandemic).

While your 2-1-1 call center manager may alert you to the fact that Rx Open has been activated, you can also check at healthcareready.org/rxopen. If it is activated, interactive maps will be available. Activations will also be announced via a message sent to partners in affected states and on Twitter @HC_Ready.

3.5 CONCEPT OF OPERATIONS – AUTOMATED PHARMACY STATUS REPORTING

1. As part of initial disaster activation, Healthcare Ready will contact participating pharmacy switching companies for activation request. Basic information on the nature and scope of the event, as well as the geographic location will be included in the request. A presidential disaster declaration is considered the baseline trigger for activation of the pharmacy status reporting, although incidents which do not rise to the level of a federal response may be considered if there is a request for pharmacy status reporting from State or Local Public Health or Emergency Management officials.

2. NCPDP will provide annual access for Healthcare Ready to their database for baseline data on pharmacies in the impacted area(s).

3. Switching agencies will provide a report of pharmacies billing prescriptions in the previous 24 hours at 2pm and 8pm EST daily using an FTP process or via email to healthcareready.org. For the purposes of information sharing, it is assumed that pharmacies that have billed for prescriptions are open for business. Fields included in the pharmacy status report:

- NCPDP ID
- National Provider ID
- Store Name
- Physical Address
- City
- State
- Zip
- Phone

4. How to Use Rx Open:

1. Go to healthcareready.org/rxopen.
2. Click on the Individual Pharmacy Map link on the right side of the screen in the Quick Links box.
3. The Individual Pharmacy Map displays community pharmacies and American Red Cross shelters in the affected area and is color coded based on operational status.
4. The best way to access information in the Rx Open Individual Pharmacy map is to click on a dot representing a pharmacy, a box appears which contains contact information.

5. Benefits of Rx Open:

- Helps patients have access to critical medicines
- Assists emergency management and public health responses
- Helps continue employment, tax base, and business continuity in a community

Reporting will be limited to the counties identified in the disaster declaration. Temporary pharmacies that have applied for and received an NCPDP ID number will be automatically included in the pharmacy status reporting. PLEASE NOTE: If you experience any issues using Rx Open or find a pharmacy status is not accurate, please email ContactUs@healthcareready.org for assistance.

3.6 REPORTING ADDITIONAL INFORMATION ON PHARMACY STATUS

If you are an authorized representative of a pharmacy and have additional information to report about a pharmacy impacted by a disaster, please contact the Healthcare Ready Operations Center at 866-247-2694. Please be prepared to provide the pharmacy status report information above, as well as additional information you wish to provide on pharmacy status, such as temporary location (tied to a pre-existing NCPDP ID) or barriers to continuing service (e.g., deliveries are not able to gain access to the disaster area).

3.7 REPORT IMPACT OF DISASTER IMPACTED LOCATIONS TO NCPDP PHARMACY DATABASE PROCESSES

Pharmacies significantly impacted by a disaster (closed long term or temporarily opened) is used by NCPDP to update the NCPDP Pharmacy database (DataQ) in the following ways:

1. List closed or destroyed pharmacies in the area.
    a. If your pharmacy has been closed or destroyed due to the natural disaster, you can logon to accessonline.ncpdp.org and request deactivation of your pharmacy. If you do not have computer access, you can call NCPDP at 480.734.2870 (phone is manned during regular business hours and a voice mail for non-business hours). If your pharmacy is scheduled to reopen, your NCPDP number will be reinstated at no charge.
    b. Deactivation will avoid the potential for fraudulent activity or inaccurate status reporting using that pharmacy's identifier.
2. List a temporary location for an existing pharmacy (with a valid NCPDP ID number) where evacuees can call to get existing prescriptions refilled and pick them up.
    a. The temporary address as well as on the physical address from the NCPDP Pharmacy Database (the "Database"). The Mailing Address of the pharmacy in the Database may or may not change, depending on the wishes of the pharmacy.
    b. When and if the store moves back to the previous location or any other location, the physical location will be changed in the Database.
3. Information on new locations of new temporary or mobile pharmacies.
    a. These pharmacies will receive an NCPDP ID number (and NPI) from NCPDP at no charge and be added to the Database.
    b. If these pharmacies are eventually closed, the pharmacy must deactivate their NCPDP ID (and NPI) by logging on to accessonline.ncpdp.org.
    c. If these pharmacies move, the pharmacy will logon to accessonline.ncpdp.org and update their physical address change. The NCPDP ID and NPI will remain the same.

4. MEDICATION HISTORY INFORMATION

The capability to adequately deliver medication history to prescribers for evacuees on a nation-wide basis exists today through ePrescribing networks; PBM claims databases, or retail pharmacy databases. To access medication history, Electronic Health Record (EHR) vendors must have an established relationship with one of these providers of medication history.

4.1 CONNECTIVITY

EHR vendors that have established connectivity with the various medication history databases will have the ability to request medication history in healthcare settings for treatment purposes. Depending on what medication history service the vendor is connected to, the data may be delivered on a real-time basis for one patient at a time, or on a bulk download basis for populations of patients within a 24-hour turn-around time. Patients who seek care from physicians who have already deployed such technology will have the ability to access medication history in the normal course of work flow. In an emergency situation, this connectivity would remain the same unless systems on either end are down. If systems are down, medication history would be unavailable unless the individual vendors have manual workarounds in place.

4.2 AUTHENTICATION

In order to comply with federal, state and local security and privacy laws, authentication of the medication history requester is necessary. For those prescribers using a certified and connected technology vendor, user authentication is the responsibility of the application vendor and is well managed today. In an emergency situation, authentication methods would remain the same unless systems on either end are down. In this case, medication history would be unavailable unless the individual vendors have manual workarounds in place, including manual authentication verification.

4.3 ADDITIONAL LIVES

Following a disaster, some payers and pharmacies not connected to a network or hub to transfer medication history, may want to contribute medication history because of geographical considerations. It is recommended these entities have the processes and procedures in place and tested so they can provide medication history information for the requested areas in a timely manner once an emergency is declared. This would allow for rapid addition of additional lives that can be accessed by clinicians and pharmacies seeing evacuees in need of care.

5. ELIGIBILITY VERIFICATION FOR BILLING/PAYMENT

Eligible individuals must enroll in EPAP prior to or while attempting to pick up prescriptions. The pharmacy must use all tools available to validate insurance availability prior to sending to EPAP, because EPAP is the payer of last resort. The NCPDP Telecommunication Standard Eligibility Verification (E1) transaction, web portals connected to centralized locations, medication history, and payer help desks are all tools used by the industry.

Eligibility information in this context contains patient information and insurance information, including supplemental insurance information. Payers send eligibility to a central site(s). With the functionality today of transaction routing, there does not need to be one central site. As long as the sites are connected, transactions can be routed between the central sites until the answer is obtained. There are models working today, using the real-time transactions or portals. The provider initiating the request uses the tools of their system or their choice, and the response is obtained via the systems behind the scenes routing requests.

The following steps need to occur before billing an EPAP transaction:

1. Ask the patient for their pharmacy ID card(s)
2. If the patient does not have any pharmacy ID card, perform an eligibility request (E1)
3. If the patient does not have private insurance, such as individual health insurance policy or employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party coverage and they are from a “declared” disaster area identified by the EPAP’s Pharmacy Benefit Manager (PBM) which is Express Script Inc. (ESI), the transaction should be billed to the EPAP. Refer to the EPAP’s PBM payer sheet and instructions sent by the EPAP processor.

6. STATE EMERGENCY PROCESSES

As each state may invoke their own programs, it is recommended the state Medicaid Agency, the state Board of Pharmacy, or the state emergency agencies be contacted for specifics.

7. FEDERAL EMERGENCY PRESCRIPTION ASSISTANCE PROGRAM (EPAP)

The EPAP must be activated by the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR) before it can be used. It will not be automatically activated, even when a Presidential Declaration is made. It is event specific. Currently, EPAP covers uninsured patients and the standard formulary is prescription drugs, medical supplies, durable medical equipment and vaccines. The website is phe.gov/EPAP. When EPAP is activated, there will be a communication section for the patients on the site.

Upon receipt of an activation notice, the EPAP Processor will inform the providers of the activation. If you have questions regarding EPAP activation information, eligibility, covered drugs and durable medical equipment, claim submission, whether you are an eligible pharmacy provider or if pharmacies would like to inquire how to become a contract provider for EPAP, please contact the **EPAP help line at 855-793-7470** for more information.

The EPAP payer sheet provides the general guidance for entities to use common requirements, to set up the emergency plan in their system ahead of time, and insert the particular emergency parameters when the emergency is activated by the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR). EPAP is used after the pharmacy has determined the patient does not have other 3rd party insurance coverage.

Patients with insurance who have the inability, due to disaster, to pay their co-pays/deductibles, should seek assistance from other disaster relief agencies or local resources. See Healthcare Ready for additional options.

7.1 EPAP ACTIVATION PROCEDURE

1. When a Federal disaster emergency is declared, Express Scripts (ESI) has 24 hours to activate EPAP coverage for the U.S. and U.S. territories.
2. Pharmacy Benefit Manager (Express Scripts Inc.) has provided the broadest retail pharmacy network with over 70,000+ stores nationwide which should include all active and credentialed pharmacies. Any retail community pharmacies wishing to participate but not in Express Scripts National Plus network, should contact ESI directly to start the credentialing process.
3. Within 24 hours of program activation, retail pharmacy communications will be faxed or emailed via existing weekly communications processes from ESI to EPAP network pharmacies.
4. The retail store communication will include:
    a. Federal disaster EPAP start date and time.
    b. Impacted zip codes.
    c. Contract number and group numbers to be used (these vary per disaster).
    d. Method of claim adjudication (electronic versus manual depending on the claim).Example) Durable Medical Equipment (i.e. Canes) will be processed via manual claim because it does not have a NDC # in retail pharmacies system. Therefore, it cannot process electronically.
    e. EPAP eligibility information, e.g. impacted individuals living in the defined disaster area and have no pharmacy insurance, are qualified for the program.
    f. Payer information is:
        i. BIN: 003858
        ii. PCN: A4
        iii. Group: Changes per disaster
        iv. EPAP member services number: 855-793-7470

5. Individuals **must first call** Express Scripts at 855-793-7470 to have their EPAP eligibility checked and be setup in the EPAP benefit before they can have a claim processed. The enrollment process takes a few minutes for the patients to have EPAP pharmacy plan.
6. NOTE: Only those who live in the Federal Emergency Management Agency (FEMA) designated disaster affected parish/county (fema.gov/disasters) and have no pharmacy insurance are eligible for the EPAP. A search will be conducted by ESI upon register for EPAP and at retail pharmacies for existing health insurance when eligibility is established.

7.2 COORDINATION OF BENEFITS

Currently, HHS/ASPR does not allow EPAP to cover out of pocket costs for patients with insurance.

8. EMERGENCY PAYER SHEET TEMPLATES

The following pages contain two emergency payer sheet templates which can be used by payers as guidance for creating their own payer sheets for eligibility and claims processing.

1. *NCPDP Emergency Preparedness Payer Sheet for Patient's Current Payer*
2. *NCPDP Emergency Preparedness Payer Sheet for the Emergency Prescription Assistance Program (EPAP)*

The emergency payer sheet templates are based on NCPDP *Telecommunication Standard Implementation Guide Version D.0*, since that is the current version in use under HIPAA. For emergency payer sheet templates for NCPDP *Telecommunication Standard Implementation Guide Version 5.1*, see a previous version of this document, since version 5.1 was sunsetted as of 01/01/2012 for HIPAA transactions.

Important guidance on NCPDP Payer Sheet Templates can be found on the NCPDP web page at ncpdp.org/Resources/HIPAA under banner "Telecommunication Version D.0", "NCPDP Payer Sheet Template for Telecommunication Version D.0".

8.1 NCPDP EMERGENCY PREPAREDNESS PAYER SHEET FOR PATIENT'S CURRENT PAYER

This payer sheet is used in emergency situations when the provider knows the patient's payer for prescription benefits. All payers are requested to be able to adjudicate the requirements in the emergency preparedness payer sheet. All providers should ensure their pharmacies know how to process claims during an emergency situation.

The use of the payer sheet is to standardize emergency procedures. The standard procedures are to clarify the use of the patient address, prior authorization numbers and the prescriber ID when the pharmacy is the prescriber.

Guidance is given in the Patient Segment for the demographic information from which the patient has been displaced. This may/may not be where the patient is residing during the emergency.

In the Prescriber Segment, guidance is given for submission of the pharmacy's NPI in emergency situations when the pharmacist may prescribe.

Submit a value of 13 in submission clarification code field (420-DK) to reject overrides during emergency/disaster requesting additional fills. Code 13 = payer - recognized emergency/disaster assistance request – The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer.

8.2 NCPDP EMERGENCY PREPAREDNESS PAYER SHEET FOR THE EMERGENCY PRESCRIPTION ASSISTANCE PROGRAM (EPAP)

This payer sheet is used in emergency situations when the provider has determined the patient does not have private insurance, such as an individual health insurance policy or employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party pharmaceutical coverage. All providers should ensure their pharmacies know how to process claims during an emergency situation, and providers should have the plan preloaded in their systems to be ready to activate in the case of an emergency.

The use of the payer sheet is to standardize an emergency payer process to provide medication and limited durable medical equipment to displaced patients who do not have any financial means of paying for prescriptions.

The standard procedures are to clarify the use of the BIN Number, patient address, prior authorization numbers and the prescriber ID when the pharmacy is the prescriber.

The allowable dates of service will be determined on an event-by-event basis.

Guidance is given in the Patient Segment for the demographic information from which the patient has been displaced. This may/may not be where the patient is residing during the emergency. This would **only** be used during a particular emergency in which the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR) has activated the Payer environment.

A note is suggested on the Days Supply (405-D5), which may be tailored based on the formal establishment of this emergency payer.

In the Prescriber Segment, guidance is given for submission of the pharmacy's NPI in emergency situations when the pharmacist may prescribe.

Eligible patients will receive coverage under the EPAP with **$0 copayments**. Pharmacies will receive reimbursement commensurate from ESI.

NCPDP Emergency Preparedness Payer Sheet for Patient's Current Payer

Revision 03/2011

This payer sheet is used in emergency situations when the provider knows the patient's payer for prescription benefits.

The use of the payer sheet is to standardize emergency procedures. The standard procedures are to clarify the use of the patient address, submission clarification codes and the prescriber ID when the pharmacy is the prescriber. This payer sheet is a recommendation for payers to begin with.

GENERAL INFORMATION

Payer Name: Name	Date: Date of Publication of this Template	
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Processor: Processor/Fiscal Intermediary		
Effective as of: Date the Plan will begin accepting transactions using this payer sheet	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: Date of Publication	NCPDP External Code List Version Date: Date of Publication	
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.		
Certification Testing Window: Certification Testing Dates		
Certification Contact Information: Certification phone number and information		
Provider Relations Help Desk Info: Phone number and information		
Other versions supported: Other versions of Telecommunication Standard supported (if applicable) and information		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0.*

Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used		

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
101-A1	BIN NUMBER	If more than one BIN/PCN but all plans use the same segments and fields and situations, enter multiple BIN/PCNs under General Information above.	M	Utilize processor current BIN number
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1	M	Billing Transaction
104-A4	PROCESSOR CONTROL NUMBER	Specify how this field is used, if not blanks.	M	
109-A9	TRANSACTION COUNT	Specify max # of transactions supported for each transaction code.	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	Specify value supported for this plan.	M	
201-B1	SERVICE PROVIDER ID		M	
401-D1	DATE OF SERVICE		M	
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

Insurance Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment **Segment Identification (111-AM) = "04"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
302-C2	CARDHOLDER ID		M	
301-C1	GROUP ID		RW	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. *Payer Requirement:* (any unique payer requirement(s))
303-C3	PERSON CODE		RW	*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID. *Payer Requirement:* (any unique payer requirement(s))
306-C6	PATIENT RELATIONSHIP CODE		RW	*Imp Guide:* Required if needed to uniquely identify the relationship of the Patient to the Cardholder. *Payer Requirement:* (any unique payer requirement(s))

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required when the patient has a first name. *Payer Requirement:* (any unique payer requirement(s))
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The street address of patient's home from where they were displaced.
323-CN	PATIENT CITY ADDRESS		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The city of patient's home from where they were displaced.
324-CO	PATIENT STATE / PROVINCE ADDRESS		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The state of patient's home from where they were displaced.
325-CP	PATIENT ZIP/POSTAL ZONE		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The zip/postal code of patient's home from where they were displaced.
307-C7	PLACE OF SERVICE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* (any unique payer requirement(s))
384-4X	PATIENT RESIDENCE		RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* (any unique payer requirement(s))

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills		

	Claim Segment Segment Identification (111-AM) = "07"			Claim Billing/Claim Rebill

Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
407-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER			*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. *Payer Requirement:* (any unique payer requirement(s))
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE			*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. *Payer Requirement:* (any unique payer requirement(s))
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER		R	
405-D5	DAYS SUPPLY		R	
406-D6	COMPOUND CODE		R	
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED			*Imp Guide:* Required if necessary for plan benefit administration. *Payer Requirement:* (any unique payer requirement(s))
354-NX	X SUBMISSION CLARIFICATION CODE COUNT		Q	Claim Billing/Encounter: Maximum count of 3. Required if Submission Clarification Code (420-DK) is used
420-DK	SUBMISSION CLARIFICATION CODE	13	Q***R***	*Claim Billing/Encounter:* *Required if clarification is needed and value submitted is greater than zero (0).* *Occurs the number of times identified in Submission Clarification Code Count (354-NX).* *13-Payer-Recognized Emergency/Disaster Assistance Request – The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer.*
308-C8	OTHER COVERAGE CODE	2, 3, 4 8		*Imp Guide:* Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers.

	Claim Segment **Segment Identification (111-AM) = "07"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Required for Coordination of Benefits. *Payer Requirement:* (any unique payer requirement(s))
461-EU	PRIOR AUTHORIZATION TYPE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED			*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:*
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID			*Imp Guide:* Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary. Required if Intermediary Authorization ID (464-EX) is used. *Payer Requirement:* (any unique payer requirement(s))
464-EX	INTERMEDIARY AUTHORIZATION ID			*Imp Guide:* Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary. *Payer Requirement:* (any unique payer requirement(s))
343-HD	DISPENSING STATUS			*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* (any unique payer requirement(s))
344-HF	QUANTITY INTENDED TO BE DISPENSED			*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* (any unique payer requirement(s))
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED			*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* (any unique payer requirement(s))

Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (430-DU) calculation.

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: (any unique payer requirement(s))
433-DX	PATIENT PAID AMOUNT SUBMITTED		R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement:* (any unique payer requirement(s))
438-E3	INCENTIVE AMOUNT SUBMITTED			*Imp Guide:* Required if its value has an effect on the Gross Amount Due (430-DU) calculation. *Payer Requirement:* (any unique payer requirement(s))
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	R	*Imp Guide:* Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. *Payer Requirement:* (any unique payer requirement(s))
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		R	*Imp Guide:* Required if Other Amount Claimed Submitted (480-H9) is used. *Payer Requirement:* (any unique payer requirement(s))
480-H9	OTHER AMOUNT CLAIMED SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (430-DU) calculation. *Payer Requirement:* (any unique payer requirement(s))
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (430-DU) calculation. *Payer Requirement:* (any unique payer requirement(s))
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (430-DU) calculation. *Payer Requirement:* (any unique payer requirement(s))
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		R	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). *Payer Requirement:* (any unique payer requirement(s))
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		R	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX).

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: (any unique payer requirement(s))
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement. *Payer Requirement:* (any unique payer requirement(s))
430-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	*Imp Guide:* Required if needed for receiver claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))

Prescriber Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	Prescriber Segment **Segment Identification (111-AM) = "03"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	12	RW	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* (any unique payer requirement(s))
411-DB	PRESCRIBER ID		RW	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s)) Use pharmacy NPI, in cases where pharmacist is allowed to prescribe.

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		Required only for secondary, tertiary, etc. claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section *Coordination of Benefits (COB) Processing* for more information.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill** Scenario 1 - Other Payer Amount Paid Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			*Imp Guide:* Required if Other Payer ID (340-7C) is used. *Payer Requirement:* (any unique payer requirement(s))
340-7C	OTHER PAYER ID			*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))
443-E8	OTHER PAYER DATE			*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement:* (any unique payer requirement(s))
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement:* (any unique payer requirement(s))
431-DV	OTHER PAYER AMOUNT PAID			*Imp Guide:* Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement:* (any unique payer requirement(s))
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:* (any unique payer requirement(s))
472-6E	OTHER PAYER REJECT CODE			*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement:* (any unique payer requirement(s))

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			*Imp Guide:* Required if Other Payer ID (340-7C) is used. *Payer Requirement:* (any unique payer requirement(s))
340-7C	OTHER PAYER ID			*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))
443-E8	OTHER PAYER DATE			*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:* (any unique payer requirement(s))
472-6E	OTHER PAYER REJECT CODE			*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement:* (any unique payer requirement(s))
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.		*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. *Payer Requirement:* (any unique payer requirement(s))
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* (any unique payer requirement(s))
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT			*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. *Payer Requirement:* (any unique payer requirement(s))
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: (any unique payer requirement(s))
393-MV	BENEFIT STAGE QUALIFIER			*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* (any unique payer requirement(s))
394-MW	BENEFIT STAGE AMOUNT			*Imp Guide:* Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s))

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			*Imp Guide:* Required if Other Payer ID (340-7C) is used. *Payer Requirement:* (any unique payer requirement(s))
340-7C	OTHER PAYER ID			*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))
443-E8	OTHER PAYER DATE			*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement:* (any unique payer requirement(s))
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			*Imp Guide:* Required if Other Payer Amount Paid

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				(431-DV) is used. *Payer Requirement:* (any unique payer requirement(s))
431-DV	OTHER PAYER AMOUNT PAID			*Imp Guide:* Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement:* (any unique payer requirement(s))
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement:* (any unique payer requirement(s))
472-6E	OTHER PAYER REJECT CODE			*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = 3 (Other Coverage Billed – claim not covered). *Payer Requirement:* (any unique payer requirement(s))
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.		*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. *Payer Requirement:* (any unique payer requirement(s))
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* (any unique payer requirement(s))
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT			*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. *Payer Requirement:* (any unique payer requirement(s))
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* (any unique payer requirement(s))

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "05"**			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
393-MV	BENEFIT STAGE QUALIFIER			*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* (any unique payer requirement(s))
394-MW	BENEFIT STAGE AMOUNT			*Imp Guide:* Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s))

DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	DUR/PPS Segment **Segment Identification (111-AM) = "08"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.		*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement:* (any unique payer requirement(s))
439-E4	REASON FOR SERVICE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
440-E5	PROFESSIONAL SERVICE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
441-E6	RESULT OF SERVICE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review

	DUR/PPS Segment **Segment Identification (111-AM) = "08"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
474-8E	DUR/PPS LEVEL OF EFFORT			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
475-J9	DUR CO-AGENT ID QUALIFIER			*Imp Guide:* Required if DUR Co-Agent ID (476-H6) is used. *Payer Requirement:* (any unique payer requirement(s))
476-H6	DUR CO-AGENT ID			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	Compound Segment **Segment Identification (111-AM) = "10"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST			*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* (any unique payer requirement(s))
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* (any unique payer

	Compound Segment **Segment Identification (111-AM) = "10"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				requirement(s))
362-2G	COMPOUND INGREDIENT MODIFIER CODECOUNT	Maximum count of 10.		*Imp Guide:* Required when Compound Ingredient Modifier Code (363-2H) is sent. *Payer Requirement:* (any unique payer requirement(s))
363-2H	COMPOUND INGREDIENT MODIFIER CODE			*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s))

Clinical Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.		*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement:* (any unique payer requirement(s))
492-WE	DIAGNOSIS CODE QUALIFIER			*Imp Guide:* Required if Diagnosis Code (424-DO) is used. *Payer Requirement:* (any unique payer requirement(s))
424-DO	DIAGNOSIS CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s))

NCPDP Emergency Preparedness Payer Sheet
for the Emergency Prescription Assistance Program (EPAP) Payer

Revision 03/2011

This payer sheet is used in emergency situations when the provider has determined the patient does not have private insurance, such as an individual health insurance policy or employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party coverage.

The use of the payer sheet is to standardize an emergency payer process to provide medication to displaced patients who do not have any financial means of paying for prescriptions.

The standard procedures are to clarify the use of the BIN Number, patient address, submission clarification codes and the prescriber ID when the pharmacy is the prescriber.

GENERAL INFORMATION

Payer Name: Express Scripts	Date:	
Plan Name/Group Name: Varies per disaster	BIN:003858	PCN: A4
Plan Name/Group Name: All	BIN:	PCN:
Effective as of: Date of emergency declaration	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: Date of Publication	NCPDP External Code List Version Date: Date of Publication	
Contact/Information Source: 1-866-935-4135		
Certification Testing Window: Certification Testing Dates		
Certification Contact Information: Certification phone number and information		
Provider Relations Help Desk Info: 1-855-793-7470		
Other versions supported: Other versions of Telecommunication Standard Supported (if applicable) and information		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e., not used) for this payer are excluded from the template.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used		

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
101-A1	BIN NUMBER	003858	M	
102-A2	VERSION/RELEASE NUMBER	D0	M	
103-A3	TRANSACTION CODE	B1	M	Billing Transaction
104-A4	PROCESSOR CONTROL NUMBER	A4	M	
109-A9	TRANSACTION COUNT	Specify max # of transactions supported for each transaction code.	M	
202-B2	SERVICE PROVIDER ID QUALIFIER	01	M	
201-B1	SERVICE PROVIDER ID		M	NPI
401-D1	DATE OF SERVICE		M	Date of Service must fall within the declared emergency period.
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

Patient Segment Questions	Check	Claim Billing/Claim Rebill *If Situational, Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "01"			Claim Billing/Claim Rebill
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
304-C4	DATE OF BIRTH		R	
305-C5	PATIENT GENDER CODE		R	
310-CA	PATIENT FIRST NAME		RW	*Imp Guide:* Required when the patient has a first name. *Payer Requirement:* (any unique payer requirement(s))
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The street address of patient's home from where they were displaced.
323-CN	PATIENT CITY ADDRESS		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The city of patient's home from where they were displaced.
324-CO	PATIENT STATE / PROVINCE ADDRESS		O	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The state of patient's home from where they were

	Patient Segment **Segment Identification (111-AM) = "01"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				displaced.
325-CP	PATIENT ZIP/POSTAL ZONE		R	*Imp Guide:* Optional. *Payer Requirement:* (any unique payer requirement(s)) The zip/postal code of patient's home from where they were displaced.

Insurance Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment **Segment Identification (111-AM) = "04"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
302-C2	CARDHOLDER ID	Beneficiary's First Initial from First Name + First Initial from Last Name + Year (YYYY) of Date of Birth + Month (MM) of Date of Birth + Day (DD) of Date of Birth.	M	Member ID
301-C1	GROUP ID		R	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment. *Payer Requirement:* Emergency Group ID as defined by the emergency processor per emergency.

Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills		

	Claim Segment **Segment Identification (111-AM) = "07"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
407-D7	PRODUCT/SERVICE ID		M	
442-E7	QUANTITY DISPENSED		R	
403-D3	FILL NUMBER		R	Refills may be extended depending upon the extent of the disaster.
405-D5	DAYS SUPPLY		R	Limited to 30 days' supply that may be extended depending upon specific disaster.
406-D6	COMPOUND CODE		R	
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	

	Claim Segment **Segment Identification (111-AM) = "07"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
415-DF	NUMBER OF REFILLS AUTHORIZED			*Imp Guide:* Required if necessary for plan benefit administration. *Payer Requirement:* (any unique payer requirement(s))
461-EU	PRIOR AUTHORIZATION TYPE CODE	1 = Prior Authorization		*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Not used for emergency situations.*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED			*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Not used for emergency situations.*

Prescriber Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational	X	

	Prescriber Segment **Segment Identification (111-AM) = "03"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	12	RW	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* (any unique payer requirement(s))
411-DB	PRESCRIBER ID		RW	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s)) Use pharmacy NPI, in cases where pharmacist is allowed to prescribe.

DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	DUR/PPS Segment **Segment Identification (111-AM) = "08"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.		*Imp Guide:* Required if DUR/PPS Segment is used. *Payer Requirement:* (any unique payer requirement(s))

	DUR/PPS Segment **Segment Identification (111-AM) = "08"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
439-E4	REASON FOR SERVICE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
440-E5	PROFESSIONAL SERVICE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
441-E6	RESULT OF SERVICE CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
474-8E	DUR/PPS LEVEL OF EFFORT			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))
475-J9	DUR CO-AGENT ID QUALIFIER			*Imp Guide:* Required if DUR Co-Agent ID (476-H6) is used. *Payer Requirement:* (any unique payer requirement(s))
476-H6	DUR CO-AGENT ID			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* (any unique payer requirement(s))

Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
409-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (430-DU) calculation. *Payer Requirement:* (any unique payer requirement(s))
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement. *Payer Requirement:* (any unique payer requirement(s))
430-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	*Imp Guide:* Required if needed for receiver claim/encounter adjudication. *Payer Requirement:* (any unique payer requirement(s))

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	Compound Segment **Segment Identification (111-AM) = "10"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST			*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* (any unique payer requirement(s))
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement:* (any unique payer requirement(s))
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 10.		*Imp Guide:* Required when Compound Ingredient Modifier Code (363-2H) is sent. *Payer Requirement:* (any unique payer requirement(s))
363-2H	COMPOUND INGREDIENT MODIFIER CODE			*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer

	Compound Segment **Segment Identification (111-AM) = "10"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				requirement(s))

Clinical Segment Questions	**Check**	**Claim Billing/Claim Rebill** *If Situational, Payer Situation*
This Segment is always sent		
This Segment is situational		

	Clinical Segment **Segment Identification (111-AM) = "13"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.		*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement:* (any unique payer requirement(s))
492-WE	DIAGNOSIS CODE QUALIFIER			*Imp Guide:* Required if Diagnosis Code (424-DO) is used. *Payer Requirement:* (any unique payer requirement(s))
424-DO	DIAGNOSIS CODE			*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* (any unique payer requirement(s))

9. MEDICATION DELIVERY IN AN EMERGENCY

9.1 HEALTHCARE READY

Healthcare Ready provides an information-sharing and problem-solving forum for the members of the private pharmaceutical supply chain system, disaster relief agencies and government to help ensure the continued delivery of critical medicines to patients whose health is threatened by a severe public health emergency. The cornerstone of Healthcare Ready is the reliance on the existing pharmaceutical supply system to provide for the continued flow of medicines and healthcare in a major public health emergency; Healthcare Ready can be used during a severe natural disaster, a large-scale terrorist attack, or a pandemic that creates disruptions to the normal supply of essential medicines.

The program provides a single point of contact for the private sector pharmaceutical supply system, enabling requests for information, pharmaceutical supply status, or pharmacy status.

Healthcare Ready offers the following resources:

- Pharmaceutical supply chain system status report on event impacts on critical healthcare and medication supplies.
- Communications network to the pharmaceutical and healthcare system to share information.
- Pharmacy status reporting via Rx Open.

Do you need contact information for the organization in this section? If so, you can ask at ContactUs@healthcareready.org, or call 866-247–2694 Website: healthcareready.org; rxopen.org.

10. MANUFACTURER PROGRAMS

10.1 THE PARTNERSHIP FOR PRESCRIPTION ASSISTANCE (PPA)

The PPA helps uninsured and financially struggling patients who lack prescription coverage get access to prescription assistance programs which offer medicines for free or nearly free. The PPA is free, confidential, and assists patients to find programs for which they may be eligible to apply.
Here are some of the services the PPA offers:

- Offers a user-friendly Web site (pparx.org) to enable patients to find prescription assistance programs for which they may be eligible to apply. Patients can download and print out patient assistance program applications immediately.
- Patients can call toll free (**888-4PPA-NOW**) to talk with a trained specialist who will guide them through the application process. The call center accepts calls in English, Spanish and approximately 150 other languages.
- Offers a single point of access to information on 475 public and private patient assistance programs, including nearly 200 programs offered by pharmaceutical companies.
- Offers more than 2,500 brand-name medicines, including a wide range of generics.
- Help patients contact government programs such as Medicaid and Medicare.
- Offers more than 40 of the assistance programs focus on the medication and healthcare needs of children.
- Provides information on nearly 10,000 free healthcare clinics and has connected more than 241,000 patients with clinics and healthcare providers in their communities.
- Assists patients with chronic disease in learning about the types of new medicines in development that may help them.

Note: This program does not offer immediate assistance for patients, but rather is a long term solution.

11. TASK GROUP COMMUNICATION PLAN

11.1 REVIEW DOCUMENT ON AN ANNUAL BASIS

This document is reviewed and updated on an annual basis by the Emergency Preparation Task Group based on the following timeline.

- Reconvene EMERGENCY PREPAREDNESS Task Group after February Work Group.
- Emergency Preparedness Task Group will review this document for accuracy and modify as necessary.
- Reviewed document will be presented for approval at May Work Group.

11.2 UPON APPROVAL BY MAY WORK GROUP

Once the document has been approved at the May Work Group meeting:

- The document will be reviewed and approved by the Standardization Committee.
- The Task Group will redistribute the updated document to all stakeholders (See Appendix B).
- The updated document will be uploaded to the NCPDP website ncpdp.org.

12. APPENDIX A. HISTORY OF DOCUMENT CHANGES

12.1 VERSION 1.1

Section *NCPDP Emergency Preparedness Payer Sheet for the Emergency Prescription Assistance Program (EPAP) Payer* has been updated to include the possibility of using a "Red Cross ID". This section has been updated to change from the Patient's Social Security Number to the Patient's "Red Cross ID".

Section *Eligibility Information* has been added.

12.2 VERSION 1.2

Information on Healthcare Ready has been added.
Reporting functionality to NCPDP has been modified.
Modifications to notification of closed pharmacies have been made with the incorporation of Healthcare Ready processes.
Emergency Prescription Assistance Program (EPAP) information has been updated.

12.3 VERSION 1.3

EPAP information has been updated to change from CMS references to the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR).

References to ICERx have been removed as this program is no longer operating.

12.4 VERSION 1.4

For Version 1.4 there were many updates and additions to the document such as:

- Updated general Grammar, Fonts and Font size, and spacing throughout the document
- Updated Hyperlinks throughout the document
- Update all references of RxResponse to Rx Open Links
- Updated Copyright details
- Added Section 2 – What Triggers an Emergency Response
- Added 3.1.2 – Ongoing item 4
- Added Section 3.1.3 – Pharmacists Prescribing and 3.1.4 – ePrescribing Renewal Request
- Update Section 3.2.1 – During Emergency To Reference Rx Open
- Added Section 3.3 Prescribers
- Modified Section 3.4 – Switch/Clearinghouse Reporting of Healthcare Ready
- Modified Pharmacy Status Reporting to Section 3.4.1 – Rx Open
- Modified Section 3.5 – Concepts of Operations – Automated Pharmacy States Reporting, added item 4 – How To Use Rx Open
- Updated Section 3.7 – Report Impact Of Disaster Impacted Locations to NCPDP Pharmacy Database Processes
- Modified Section 4 – Medication History Information
- Combined Section 2 – What Do I Need To Do and Section 3 – Pharmacy Status Reporting into Section 3 – What Do I Need To Do

- Removed Section 4.2 – Portal
- Modified Section 5 – Eligibility Verification for Billing/Payment
- Added Section 7.1 – EPAP Activation Procedure
- Update Section 3.1.1 – During Emergency To Reference Rx Open
- Modified Section 8.1 – NCPDP Emergency Preparedness Payer Sheet For Patient's Current Payer
- Modified Section 9.1 – RxResponse to 9.1 – HealthcareReady
- Clarifications to Section 10.1 – The Partnership For Prescription Assistance (PPA)
- Added Section 11 Task Group Communication Plan
- Added Section 13 – Appendix B Stakeholders

13. APPENDIX B

13.1 STAKEHOLDERS

1. AMA
2. AMCP
3. AMDIS
4. ASHP
5. ASPR
6. Change Healthcare
7. Healthcare Ready
8. NABP
9. NACDS
10. NAMD
11. NCPA
12. NGA
13. PCMA
14. Relay Health
15. Surescripts

AMA
American Medical Association
AMA Plaza
330 N. Wabash Ave
Chicago, IL 60611-5885
Phone: 800-621-8335
Web: ama-assn.org/ama

AMCP
Academy of Managed Care Pharmacy
675 North Washington Street, Suite 220
Alexandria, VA 22314
Phone: 703-684-8600
Fax: 703-684-2651
Web: amcp.org

AMDIS
Association of Medical Directors Information Systems Inc.
682 Peninsula Drive
Lake Almanor, CA 96137
Phone: 719-548-9360
Email: info@amdis.org
Web: amdis.org

ASHP
American Society of Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, MD 20814

Phone: 866-279-0681
Fax: 301-657-1251
Email: custserv@ashp.org

ASPR
U.S. Department of Health and Human Services
Office of the Assistant Secretary for Preparedness and Response
200 Independence Avenue, S.W., Room 638G
Washington, DC 20201
Critical Infrastructure Protection for the Healthcare and Public Health Sectors (CIP)
Email: cip@hhs.gov
ASPR Prescription Medication Preparedness Initiative (PMPI)
Contact: Lauren Walsh
Phone: 202-205-4369
Email: lauren.walsh@hhs.gov
Contact: Gregg Margolis, Alternate contact for PMPI
Phone: 202-690-3830
Email: Gregg.margolis@hhs.gov

Change Healthcare
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Healthcare Ready
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Email: ContactUs@HealthcareReady.org
Web: healthcareready.org

NABP
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1600 Feehanville Drive
Mount Prospect, IL 60056
Phone: 847-391-4406
Fax: 847-375-1114
Email: ExecOffice@nabp.pharmacy

NACDS
National Association of Chain Drug Stores
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
Phone: 703-549-3001
Fax: 703-836-4869
Email: contactus@nacds.org

NAMD

National Association of Medicaid Directors - State Medicaid Directors
Contact: Matt Salo, Executive Director
Phone: 202-403-8621
Email: matt.salo@medicaiddirectors.org
Web: medicaiddirectors.org

NCPA
National Community Pharmacists Association
100 Daingerfield Road
Alexandria, VA 22314
Phone: 703-683-8200 Voice: 800-544-7447
Fax: 703-683-3619
Email: info@ncpanet.org

NGA
National Governors Association
Hall of the States
444 North Capitol Street, Suite 267
Washington, DC 20001-1512
Phone: 202-624-5300
Fax: 202-624-5313
Email: webmaster@nga.org

PCMA
The Pharmaceutical Care Management Association
325 7th Street, NW 9th Floor
Washington, DC 20004
Phone: 202-756-5700
Fax: 202-756-5708

RelayHealth
Relay Health
1564 Northeast Expressway
Atlanta, GA 30329-2010
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Contact: Amy Valli, Manager, Public Relations
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