New Jersey

NCPDP

D.0/1.2

Payer Sheet

Table of Contents

Section 1 Version History

This section lists additional changes made to this **November 2023 Version** of the New Jersey NCPDP D.0/1.2 Payer Sheet compared to the previous version.

November 2023 Version	
Page #	**Change**
34	Changed requirements for field 420-DK in the AM07 Claim Segment.
July 2023 Version	
Page #	**Change**
42	Changed requirements for field 506-F6 in the AM23 Response Pricing Segment.
January 2023 Version	
Page #	**Change**
36	Changed requirements for field 423-DN in the AM11 Pricing Segment.
October 2021 Version	
Page #	**Change**
34	Changed requirements for field 420-DK in the AM07 Claim Segment.
September 2021 Version	
Page #	**Change**
34	Changed requirements for field 420-DK in the AM07 Claim Segment.
January 2021 Version	
Page #	**Change**
7	Changed e-mail address for State NCPDP Coordinator.
26	Added Section 6.2 Transaction Specifications. Also added descriptions of Prescription Drug Plan for PDP, Processor Control Number for PCN.
27	Added description of Coordination Of Benefits for COB.
34	Changed requirements for field 420-DK in the AM07 Claim Segment.
35	Added description of Drug Utilization Review for DUR and Professional Pharmacy Service for PHP. Also changed requirements for field 440-E5 in the AM08 DUR/PPS Segment.
36	Changed requirements for field 438-E3 in the AM11 Pricing Segment.
41 - 44	Added Section 8 NCPDP D.0 Response Specifications and Section 8.1 Accepted (Paid) Response Transactions Format.
45 – 47	Added Section 8.2 Rejected Response Transactions Format.
48	Added Section 8.3 Accepted Reversal Response Transactions Format.
49	Added Section 8.4 Rejected Reversal Response Transactions Format.
52	Added description of Electronic Media Claims for EMC.
November 2020 Version	
Page #	**Change**
Throughout Document	Changed references from DXC Technology to Gainwell Technologies.
September 2020 Version	
Page #	**Change**
32	Changed requirements for fields 456-EN, 457-EP and 415-DF in the AM07 Claim Segment.
33	Added field 460-ET Quantity Prescribed and changed requirements for fields 343-HD, 344-HF and 345-HG in the AM07 Claim Segment.

Page #	Change
March 2020 Version	
Page #	**Change**
32	Added requirement; (Must be 00 for Compound claims) for field 436-E1 in the AM07 Claim Segment.
38	Added requirement; (Must be 00 for Compound claims) for field 436-E1 in the AM07 Claim Segment in Section 7.1 Reversal Transactions Format.
April 2019 Version	
Page #	**Change**
37	Added comments to 7.1 Reversal Transactions Format requesting to not submit segments that are not required for reversals.
38	Removed AM04, AM08 and AM11 segments from Section 7.1 Reversal Transactions Format.
October 2018 Version	
Page #	**Change**
Throughout Document	Changed references from Molina Medicaid Solutions to DXC Technology.
April 2018 Version	
Page #	**Change**
32	Added requirement; Valid values are 1 (non-compound) or 2 (compound) for field 406-D6 and changed usage from "M" mandatory to "O" optional for field 415-DF in the AM07 Claim Segment.
33	Changed usage from "M/O" to "O" optional for field 357-NV in the AM07 Claim Segment.
January 2018 Version	
Page #	**Change**
33	Added requirement; Enter values 01 – 18 for field 450-EF Compound Dosage Form Description Code in AM10 Compound Segment.
34	Changed usage for field from "M" mandatory to "O" optional for field 412-DC Dispensing Fee Submitted. Added requirement; Value entered must be greater than 0 for field 409-D9 Ingredient Cost Submitted. And added requirement; Value entered must be greater than 0 for field 430-DU Gross Amount Due in the AM11 Pricing Segment.
35	Changed usage for field from "M" mandatory to "O" optional for field 424-DO Diagnosis Code in the AM13 Clinical Segment.
March 2017 Version	
Page #	**Change**
34	Added requirements for field 423-DN Basis of Cost Determination in the AM11 Pricing Segment.
August 2015 Version	
Page #	**Change**
6	Changed New Jersey DMAHS NCPDP Coordinator contact information.
October 2014 Version	
Page #	**Change**
8	Changed the HIPAA Claims Link to the HIPAA Submitter Login Link to reflect the name change of the link.
9,10	Removal of the CD-ROM info.
35	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015.
October 2013 Version	
Page #	**Change**
36	Revised requirements for fields 492-WE and 424-DO in the AM13 segment.

April 2013 Version	
Page #	**Change**
9	Revised Section 3.7 changing the interchange naming convention to allow for a numeric character or one of eight special characters to also be used in the file name and revised the examples of allowable file names.
31	Changed requirements for field 352-NQ in AM05 segment.

October 2012 Version	
Page #	**Change**
Through out	Changed version date to October 2012. Changed Provider Services to EDI Unit. Also changed Billing Agent to Billing Service.
6	Sect. 2.2, 2nd para., changed last sentence and removed sentence and in 3rd para, changed date.
7	Sect. 3.2 changed paragraph to reference HIPAA specific documents and in 4th para., Changed last sentence of paragraph. In Sect. 3.3, line 3. 2nd bullet, deleted sentence and on line 3., deleted 3rd bullet.
8	Sect. 3.3, line 5., second bullet, deleted reference to 997.
11	Sect. 4, 1st and 2nd bullets, added form names.
12	Added form name.
12,15,17,21,22	Changed form title and/or form name
15	5) added (must be original).
16	24) added (must be original).
18	Added form name.
21	13) added (must be original).
22	16) deleted references to old versions.
23	Added form name.
24	Replaced with latest version of form.
26	Changed NJ Specific Requirements for fields 103-A3 Transaction Code and 104-A4 Processor Control Number.
28	Changed requirements for fields 466-EZ and 411-DB Prescribing ID deleting HIPAA Non-Covered Entities comments in AM03 segment.
31	Changed requirements for field 351-NP Other Payer-Patient Responsibility Amount Qualifier deleting values.
35	Changed requirements for field 492-WE Diagnosis Code Qualifier changing date to 2014.
36	Revised Usage comment for AM15 segment.
37	Changed NJ Specific Requirements for field 104-A4 Processor Control Number.
38	Changed NJ Specific Requirements for field 402-D2 Prescription/Service Reference Number.

November 2011 Version	
Page #	**Change**
15-17	Made revisions to EDI Agreement headers.
18	Made revisions to EDI Agreement instructions adding Pharmacy Provider Number and NPI.
21-22	Made revisions to EDI Agreement headers. Also added Pharmacy Provider Number and NPI fields to EDI Agreement.
27	Changed NJ Specific Requirement for field 335-2C Pregnancy Indicator.
31	Revised NJ Specific Requirements for field 351-NP Other Payer-Patient Responsibility Amount Qualifier.

August 2011 Version	
Page #	**Change**
22-23	Added Sections 5 and 5.1 for Submitter File EDI Update From.
31	Revised NJ Specific Requirements for field 408-D8 Dispense As Written.

March 2011 Version	
Page #	**Change**
All	1st Production/4th DRAFT Version of the New Jersey NCPDP D.0/1.2 Payer Sheet for the NCPDP Version D.0 and 1.2 Batch Version transaction sets. Document renamed from DMAHS Pharmacy NCPDP-HIPAA Companion Guide to New Jersey NCPDP D.0/1.2 Payer Sheet.
March 2011 Version - continued	
Page #	**Change**
9	Added Section 4 Trading Partner Agreements containing EDI Agreement. Repagination of document renumbering remaining sections.
14	Added Section 4 Trading Partner Agreements containing EDI Agreement.
15 – 17	Added New Jersey Submitter ID/Provider Relationship Agreement instructions.
18 – 20	Added New Jersey Submitter ID/Provider Relationship Agreement.
21 – 23	Added New Jersey Pharmacy Submitter EDI Agreement instructions.
24 – 25	Added New Jersey Pharmacy Submitter EDI Agreement.
26	Added Part D COB to 1st 3 bullet items for comments on field 104-A4 Processor Control Number.
27	Revised paragraph describing NJ Specific Requirement column, renamed NJ Medicaid Specific Requirement column heading in table, changed page #s referenced in fields 103-A3 & 104-A4.
28	Changed format lengths for fields 401-D1 & 110-AK.
29	Revised NJ Specific Requirement comments for fields 302-C2 & 303-C3.
30	Revised paragraphs describing COB/Other Payments Segment and field 472-6E Other Payer Reject Code, revised NJ Specific Requirement comments for field 337-4C.
31	Added Payer Code for Medicare C Plans for field 340-7C. Revised Usage and NJ Specific Requirement comments for field 341-HB.
32	Revised NJ Specific Requirement comments for fields 342-HC, 431-DV, 471-5E, 472-6E, 353-NR, 351-NP, 352-NQ, 392-MU & 393-MV.
33	Revised NJ Specific Requirement comments for fields 402-D2 & 308-C8. Removed NJ Specific Requirement comments for fields 458-SE, 459-ER & 415-DF.
34	Removed NJ Specific Requirement comments for fields 357-NV & 441-E6. Corrected spelling of AM10 segment name.
36	Combined multiple table entries into one for field 492-WE. Revised Usage comment for AM15 segment. Revised Usage for fields 111-AM (13), 491-VE, 492-WE, 424-DO, 111-AM (13) & 336-8C. Added NJ Specific Requirement comments for 336-8C.
38	Changed page # referenced in field 104-A4. Revised format length for fields 401-D1 & 110-AK.
39	Changed page # referenced in field 402-D2 and revised NJ Specific Requirement comments. Removed AM05 Segment.
40	Changed page # referenced in field 103-A3.
41-49	Removed Response sections.

Section 2   Introduction

2.1   New Jersey DMAHS Introduction

New Jersey Division of Medical Assistance and Health Services (DMAHS) and Gainwell Technologies are very pleased to make available this November 2023 Version of the New Jersey NCPDP D.0/1.2 Payer Sheet. This document represents our ongoing effort to adhere to the HIPAA transaction set requirements. HIPAA provides all healthcare entities a tremendous opportunity to realize many administrative and systemic benefits because it provides a national standard of transaction and code sets for the electronic exchange of healthcare information. New Jersey DMAHS and Gainwell Technologies are committed to the implementation of all HIPAA transaction sets as the sole format for all state and federal programs processed through the New Jersey Medicaid Management Information System (NJMMIS).

The purpose of this manual is to provide information necessary to electronically submit Point of Sale (POS) claims and Pharmacy Electronic Data Interchange (EDI) claims to Gainwell Technologies, our fiscal agent. HIPAA requirements apply to all State Pharmacy benefit claims including Medicaid and NJ FamilyCare Fee-For-Service (FFS) pharmacy claims, Pharmaceutical Assistance to the Aged and Disabled (PAAD), Senior Gold Prescription Discount Program, AIDS Drug Distribution Program (ADDP), and Cystic Fibrosis (CF) program. This manual is to be used in conjunction with the National Electronic Data Interchange Transaction Set Implementation Guides. The Implementation Guides can be obtained exclusively from NCPDP for members by calling 1-480-477-1000 or are available for download on their web site at www.ncpdp.org. The Implementation Guides provide the National HIPAA transaction and code set requirements, compared to the New Jersey NCPDP D.0/1.2 Payer Sheet, which only provides the supplemental requirements specific to New Jersey DMAHS, as permitted within the structure of the NCPDP-HIPAA transaction sets. All providers who submit claims electronically to New Jersey DMAHS must adhere to the NCPDP-HIPAA Implementation Guide and the New Jersey NCPDP D.0/1.2 Payer Sheet requirements.

This Payer Sheet addresses the NCPDP Version D.0 and 1.2 Batch Version transaction sets.

HIPAA does not mandate the use of these transaction sets for the exchange of healthcare data. Any provider may continue to submit paper claims, except for compound drugs, and receive a paper remittance advice. However, if a provider elects to submit claims electronically and/or receive an electronic remittance advice, HIPAA does require the use of standard transaction and code sets.

Please note that there is a level of interpretation required when reviewing the Implementation Guides. Additional changes may be required to bring our Payer Sheet in line with the intent of the Implementation Guides. Therefore, this document is subject to change.

All comments, suggestions, and/or questions regarding this Payer Sheet should be directed to the New Jersey DMAHS NCPDP Coordinator:

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New Jersey Medicaid
P.O. Box 712
Trenton, NJ 08625-0712
Phone: 609-588-6064
Email: timothy.brembos@dhs.nj.gov

Submitters are requested to refrain from contacting Gainwell Technologies Provider Services regarding related HIPAA issues and questions.

2.2 HIPAA Background

In the early 1990s, the Bush Administration assembled an advisory group of health care industry leaders to discuss ways to reduce health care administrative costs across the nation. This group, which is now recognized as the Workgroup for Electronic Data Interchange (WEDI), recommended that Federal legislation be passed to implement a nationwide standard of transaction and code sets to be used by the healthcare industry. This law was entitled "The Health Insurance Portability and Accountability Act" (HIPAA) and was enacted on August 21, 1996 under the Clinton Administration.

HIPAA requires several provisions. One such provision dealt with the portability of health insurance coverage during a change in employment, and primarily affected employers and health insurers. This provision has already gone into effect. Another provision often referred to "Administrative Simplification", deals with the implementation of healthcare standards, of which transaction and code sets are but one part. October 16, 2003 HIPAA mandated the use of the 4010 versions and NCDPD versions 5.1 and 1.1 versions for batch claims. On May 1, 2012, versions D.0 and 1.2 were mandated.

Although this Payer Sheet deals with electronic pharmacy (NCPDP) claims transaction sets, there were several others that were required by the mandatory implementation date of June 29, 2012.

- Eligibility Inquiry and Response: HIPAA mandates the use of Version 5010 of the X12 270/271 Eligibility & Benefit Inquiry & Response EDI Transactions for this purpose.

- Claim Transaction Sets: HIPAA mandates the use of 837 Professional, Institutional, and Dental transaction sets. (Please see the New Jersey HIPAA 837 Companion Guide at www.njmmis.com for specific New Jersey implementation dates.)

- Claim Status: HIPAA mandates the use of Version 5010 of the X12 277P Health Care Claim Pending Status Information EDI Transaction for this purpose.

- Remittance Advice: HIPAA mandates the use of Version 5010 of the X12 835 Health Care Claim Payment/Advice EDI Transactions for this purpose.

- Referral Certification & Authorization: HIPAA mandates the use of Version 5010 of the X12 278 Health Care Service Review EDI Transaction for this purpose.

- Enrollment & Disenrollment: HIPAA mandates the use of Version 5010 of the X12 834 Benefit Enrollment & Maintenance EDI Transaction for this purpose.

- Premium Payment & Remittance Advice: HIPAA mandates the use of Version 5010 of the X12 820 Group Premium Payment EDI Transaction for this purpose.

HIPAA also requires the standardization of code sets. Any coded field or data element contained in a HIPAA transaction must adhere to a national set of code set values, including medical services and diagnoses. As such, New Jersey DMAHS is required to discontinue the use of local codes, including pharmacy edit codes.

Section 3   Electronic Data Interchange

3.1   Telecommunication Specifications

Internet Specifications (*NCPDP 1.2 Batch Submissions Only*)

New Jersey Medicaid and Gainwell Technologies have deployed an Internet-based solution that will allow the electronic exchange of NCPDP 1.2 batch transactions through the **HIPAA Submitter Login** link on the NJMMIS Web site www.njmmis.com.   NCPDP 1.2 batch transactions can be sent seven days a week, Sunday thru Saturday, with the following exceptions, which have been scheduled as maintenance windows.

- Wednesdays, 10 p.m. thru Thursdays 2 a.m. and
- Saturdays, 8 p.m. thru Sundays 4 a.m., Eastern time.

NCPDP 1.2 batch submitters using the Web site will drop-off NCPDP 1.2 batch files and pick-up Response files through a secure area of the New Jersey Medicaid Web site. A valid Submitter Username and Password is required before access is granted for drop-off and pick-up.

3.2   Submitter Registration - Obtaining a Username and Password

EDI Submitters will be registered on the submitter database upon processing of their New Jersey Medicaid HIPAA EDI Agreement and will receive their Submitter Username and Password via the United States Postal Service. The New Jersey Medicaid HIPAA EDI Agreements and instructions are found on the www.njmmis.com New Jersey Medicaid Web site on the Forms & Documents link. To locate HIPAA specific documents, Choose a Type: All and Choose Topic: HIPAA, press the Submit Request button.

To obtain a username and password, you must submit a Pharmacy Submitter EDI agreement (NCPDP - 101 Form). Submitters are expected to maintain their own passwords and will be able to change their password through a link on the **NJMMIS** Web site.

3.3   Logging In To Web Site (*NCPDP 1.2 Batch Submissions Only*)

1. After receiving your username and password, access the web site (www.njmmis.com) and select the HIPAA SUBMITTER LOGIN link from the menu options on left side of screen.

2. Enter your Submitter Username and password and click on Submit.

3. On the **Welcome to the New Jersey Medical Assistance Program Transaction Services Home** screen click on the **upload** link at the upload or download HIPAA files link to upload files for processing.

   - Only files in the approved HIPAA formats may be uploaded.

   - Gainwell Technologies will only accept NCPDP 1.2 Batch and D.0 formats.

   - You can upload up to five files at a time. All files being submitted must be of the same type as indicated in the file type selection area (i.e., up to five NCPDP 1.2 batch files can be submitted at one time. If you wish to also submit 837 – 005010X222A1 Professional files, these must be sent after the previous file type has been submitted.

   - Users should allow 30 seconds or more before submitting additional files allowing for file processing between upload attempts.

- The combined file size must not exceed 20 MB for NCPDP 1.2 batch files. If multiple files are being submitted at one time, the combined file sizes must not exceed 20 MB.

- While a combined file size of up to a maximum size of 20 MB for NCPDP 1.2 may be submitted, Gainwell Technologies will not perform detailed analysis on files in excess of 5 MB when assisting submitters in resolving errors resulting in the full or partial rejection of a submission. Submitters requiring the technical assistance of Gainwell Technologies EDI staff will be requested to resubmit the claims in question with one or more files where the file size does not exceed 5 MB.

- Files must be in ZIP or DAT format only. Please refer to the section on Interchange Naming Convention discussed later in this section for additional information regarding compressed files and naming conventions.

4. Click on the download link at the Upload or download HIPAA files prompt to download (pick-up) your 835 and 277P remittance files.

- 835 and 277P remittance files are available for downloading the Wednesday following the weekend processing cycle.

5. Click on the **Recent Uploads** link of the View a list of Recent Uploads prompt to view the status of the NCPDP 1.2 batch file and to pick-up the Response file.

- The TA1/Error column will report if there were any initial errors found in the file or "No Error" is reported upon initial processing of the file.

- The 999 Response column will report if the Response file is available. The Response file will be available on the morning following the running of the NCPDP 1.2 batch file thru the NJMMIS POS system if no initial errors are reported in the TA1/Error column.

- The Response file available for downloading will follow the following naming convention.

Submitter ID#_Batch#.000.rsp

3.4   Interchange Naming Convention (*NCPDP 1.2 Batch Submissions Only*)

For the submission of NCPDP 1.2 batch transactions thru the web, New Jersey Medicaid will support the DOS file-naming convention of 8-characters followed by a 3-character extension.

The naming convention for batch files is as follows:

The file name format MUST be one alphabetic character (A - Z) or one numeric character (0 - 9) or one of eight special characters (~, @, #, $, %, ^, &, +) followed by the 7-digit EDI Submitter ID Number (assigned by Gainwell Technologies) with the REQUIRED 3-character extension of .DAT. The eight special characters listed are the only special characters that will be allowed. If any other special characters are used, the file will be rejected at the time of submission.

Example: A1234567.DAT or 01234567.DAT or #1234567.DAT

Any interchanges that do not follow this naming convention will NOT be processed. The EDI Submitter number in the interchange name MUST match the EDI Submitter number in the Transaction Header Segment.

NCPDP 1.2 batch submissions may include any number of claims as long as the size of the interchange being submitted does NOT exceed 20 megabytes. There is no minimum or maximum number of claims required for an EDI submission, regardless of the media or method of submission, except that the size of the interchange

being submitted does NOT exceed 20 MB. **EDI submissions with file properties set to "READ ONLY" will NOT be accepted.**

Multiple interchanges may be sent daily however an EDI Submitter is NOT to exceed more than **999** interchanges in a day (from the period of midnight to midnight).

Only one Transaction Header and Trailer Record must be contained within a file.

Multiple files may be submitted in a compressed format with a .zip file extension (i.e., multiple files within one .zip file, all files containing only one Transaction Header and Trailer Record.)

A1234567.zip – Compressed file
      A1234567.dat – 1st file in compressed file
      B1234567.dat – 2nd file in compressed file
      C1234567.dat – 3rd file in compressed file

If multiple files are being submitted at one time the combined file sizes must not exceed 20 MB.

Section 4   Trading Partner Agreements

All New Jersey Medicaid and other state benefit program pharmacy providers desiring to submit NCPDP D.0 or 1.2 HIPAA formatted electronic claims must complete a New Jersey EDI Agreement as part of the trading partner agreement as required by HIPAA guidelines.

Pharmacy Submitters who are currently enrolled with Gainwell Technologies for the submission of 5.1 or 1.1 HIPAA formatted electronic claims and have completed and returned the Addendum to the existing EDI Agreement do NOT have to complete the EDI Agreements included in this Payer Sheet. The Addendum Agreement replaces the previously executed EDI Agreement on file with Gainwell Technologies.

All other pharmacy providers who are currently not enrolled to submit pharmacy claims electronically with Gainwell Technologies must complete one of the following New Jersey EDI Agreements.

- Pharmacy providers using a Clearing House/Billing Service for submission of NCPDP D.0 or 1.2 HIPAA formatted electronic claims to Gainwell Technologies via the Switch Vendor (for D.0) or via the website (for 1.2) must complete the **Submitter ID/Pharmacy Relationship Agreement (Form NCPDP-201)**.

- Pharmacy providers using a software application which allows direct submission of NCPDP D.0 or 1.2 HIPAA formatted electronic claims to Gainwell Technologies via the Switch Vendor (for D.0) or via the website (for 1.2) must complete the **Pharmacy Submitter EDI Agreement (Form NCPDP-101).**

The New Jersey EDI Agreement must be prior approved and on file with Gainwell Technologies before NCPDP D.0 or 1.2 HIPAA formatted claims may be submitted electronically. Gainwell Technologies will notify the EDI Submitter of its approval for the submission of NCPDP D.0 or 1.2 HIPAA formatted electronic claims.

Pharmacy providers using a Clearing House/Billing Service to submit NCPDP D.0 or 1.2 HIPAA formatted electronic claims must complete the New Jersey EDI Agreement along with the billing service. The billing service is responsible for ensuring that each pharmacy provider properly completes and submits these agreements to Gainwell Technologies. If the agreement is not properly completed, it will be returned to the submitter.

Pharmacy providers must notify Gainwell Technologies in writing when the use of a billing service for the submission of electronic claims has been terminated. When a pharmacy provider switches billing services, the new billing service must ensure that the pharmacy provider completes a new, New Jersey EDI Agreement form and submit it to Gainwell Technologies. Gainwell Technologies will notify the billing service when approval for the pharmacy provider to submit claims electronically has been granted.

Pharmacy providers must notify Gainwell Technologies in writing when their use of a software developer's application for the direct submission of electronic claims to Gainwell Technologies has been terminated. When a pharmacy provider switches to a new software developer's application, the pharmacy provider must complete a new, New Jersey EDI Agreement form and submit it to Gainwell Technologies. Gainwell Technologies will notify the pharmacy provider when approval to submit claims electronically has been granted.

A new agreement must be completed when a pharmacy provider or billing service changes ownership.

All New Jersey EDI Agreements **MUST** be submitted to Gainwell Technologies with **ORIGINAL** signatures. Facsimile copies of agreements will **NOT** be accepted. If the agreement is not properly completed, Gainwell Technologies will return it.

4.1 __New Jersey Submitter ID/Pharmacy Relationship Agreement (Form NCPDP-201) - Instructions__

WHO SHOULD COMPLETE THIS AGREEMENT?

Both the Submitter (who is the Billing Service) and the NJ Medicaid Provider. Currently the Submitter has a Submitter ID and provides software to a provider. The provider enters claim information locally and passes the claim information to the Billing Service who then forwards the claim to the Switch Vendor for processing.

SECTION 1: SUBMITTER INFORMATION

1. **Submitter Name**: Enter the name of the Pharmacy or Clearing House/Billing Service Name as registered with New Jersey Medicaid/Gainwell Technologies.

2. **Submitter ID:** Enter the Submitter ID as assigned by Gainwell Technologies.

3. **Submitter Street Address**: Enter the physical street address of the Pharmacy or Clearing House/Billing Service. This MUST be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

4. **City, State, Zip Code**: Enter the city, state and zip code. This MUST be part of the physical address.

5. **Submitter Representative's Signature**: This MUST be an actual signature of the pharmacy owner or Billing Service. THIS MAY NOT BE STAMPED. This person should have liability authority of the business.

6. **Date Signed**: Date signature was placed on this form.

7. **Submitter Representative's Name**: PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 5 above).

8. **Submitter Representative Telephone/EXT:** Enter the phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone.

9. **FAX:** Enter the FAX number of your place of business.

10. **Submitter Representative Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your Submitter file profile. This email address will be used to send a confirmation to acknowledge the processing of the EDI AGREEMENT and confirm your submitter profile has been updated to allow you to send TEST NCPDP D.0 or 1.2 claims.

11. **2nd Submitter Contact Person:** Enter the name of a person in the event Gainwell Technologies needs to contact someone from your company.

12. **PHONE/EXT:** Enter the secondary phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone.

13. **2nd Submitter Contact Person Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your Submitter file profile. This email address will be used to send a confirmation to acknowledge the processing of the EDI AGREEMENT and confirm your submitter profile has been updated to allow you to send TEST NCPDP D.0 or 1.2 claims

SECTION 2: PROVIDER INFORMATION

14. **Action Requested:** Please check appropriate box if you are either adding a new provider number to be linked to your Submitter ID or terminating an existing provider from your Submitter ID.

15. **Provider Name:** Enter the BUSINESS name of the provider as they are registered with Gainwell Technologies.

16. **New Jersey Medicaid Pharmacy Provider Number:** Enter the New Jersey Medicaid Pharmacy Provider number assigned to the provider by Gainwell Technologies.

17. **Pharmacy NPI Number:** Enter the NPI number of the Pharmacy as assigned by NPPES and registered with Gainwell Technologies.

18. **Provider Street Address:** Enter the physical street address of the provider's place of business or service address as it is registered with Gainwell Technologies. This **MUST** be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

19. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

20. **Provider EDI Contact Person:** Enter the name of a person from the pharmacy place of business in the event Gainwell Technologies needs to contact someone at the provider level.

21. **Phone/Ext:** Enter the phone number along with the extension of a person from the pharmacy or place of business in the event Gainwell Technologies needs to contact someone.

22. **FAX :** Enter the FAX number of the pharmacy place of business.

23. **Email Address: PLEASE PRINT CLEARLY.** Enter the Email address of a contact person from the pharmacy's place of business in the event Gainwell Technologies needs to contact someone.

24. **Provider Representative's Signature**: This MUST be an actual signature of the New Jersey provider or pharmacy owner. THIS MAY NOT BE STAMPED. This person should have liability authority of the business.

25. **Date Signed**: Date signature was placed on this form.

26. **Provider Representative's Name**: PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 24 above).

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

27. **SOFTWARE VENDOR NAME:** Enter the BUSINESS name of the Software Vendor**.**

28. **STREET ADDRESS:** Enter the physical street address of the software vendor. This MUST be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction**.**

29. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

30. **SOFTWARE CONTACT PERSON:** Enter the name of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

31. **PHONE/EXT:** Enter the phone number along with the extension of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

32. **SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the Email address of a contact person from the software company in the event Gainwell Technologies needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

33. **2nd SOFTWARE CONTACT PERSON:** Enter the name of a secondary person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

34. **PHONE/EXT:** Enter a secondary phone number along with the extension of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

35. **2nd SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the Email address of a second contact person from the software company in the event Gainwell Technologies needs to contact someone at the software company to correspond with for updates, changes, problems etc., with software.

36. **FAX :** Enter the FAX number of the software company.

37. **SOFTWARE PRODUCT NAME:** If a software company has multiple products, please enter the name of the product you are installing for NCPDP D.0/1.2.

38. **SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME:** Please enter the release number of the software product you are installing for NCPDP D.0/1.2**.**

39. **SOFTWARE PRODUCT RELEASE DATE:** Please enter the release date of the software product you are installing for NCPDP D.0/1.2**.**

Return the completed EDI Agreement to Gainwell Technologies at the following address:

<table>
<tr><td align="center"><u>Via U.S. Mail</u></td><td align="center"><u>Other Carriers</u></td></tr>
<tr><td align="center">EDI Unit</td><td align="center">EDI Unit</td></tr>
<tr><td align="center">Gainwell Technologies</td><td align="center">Gainwell Technologies</td></tr>
<tr><td align="center">P.O. Box 4804</td><td align="center">3705 Quakerbridge Road, Suite 101</td></tr>
<tr><td align="center">Trenton, New Jersey 08650 – 4804</td><td align="center">Trenton, New Jersey 08619</td></tr>
</table>

For Internal Use Only				☐ POS
EMCAGREE				☐ BATCH
DOCTYPE	*Submitter ID*	*Submitter & Provider Name*		☐ E-RA
				☐ SIGN
				☐ ADD
Update Initials	*Date*	*QA Initials/Date*	*Provider Group Number*	☐ TERM

state of new jersey — SUBMITTER ID/PHARMACY RELATIONSHIP AGREEMENT

SECTION 1: SUBMITTER INFORMATION

Every EDI submitter assigned a Submitter ID by New Jersey Medicaid must complete, sign and submit this New Jersey Medicaid Submitter ID/Pharmacy Relationship Agreement before the submitter is authorized to submit claims for a New Jersey Medicaid provider. In some cases the submitter may be a New Jersey Medicaid provider and in other cases the submitter may be a third party billing service. Regardless, New Jersey Medicaid cannot process claims submitted with a specific Submitter ID for a specific New Jersey Medicaid provider number unless this agreement has been properly completed and submitted to New Jersey Medicaid or their designated agent. By signing this agreement, the New Jersey Medicaid provider is authorizing the submitter to submit claims electronically to New Jersey Medicaid on their behalf.

A separate agreement is required for each New Jersey Medicaid Billing Provider Number.

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

1) Submitter Name: _____

2) Submitter ID: _____

3) Submitter Street Address: _____
   (P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

4) City, State, Zip Code: _____

5) Submitter Representative's Signature (must be original) _____   6) Date Signed _____

7) Submitter Representative's Name – Please Print _____

8) Submitter Representative Telephone Number/Ext: (_____) _____/ _____   9) FAX :(_____) _____

10) Submitter Representative Email Address: _____

11) 2nd Submitter Contact Person: _____ 12) Phone/Ext:(_____) _____/_____

13) 2nd Submitter Contact Person Email Address: _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

Submitter Name: _____   Submitter #: _____

SECTION 2: PROVIDER INFORMATION

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

14) Action Requested:

☐ Add New Provider   ☐ Terminate Existing Provider

15) Provider Name: _____

16) New Jersey Medicaid Pharmacy Provider Number: _____

17) Pharmacy Provider NPI Number: _____

18) Provider Street Address: _____
   (P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

19) City, State, Zip Code: _____

20) Provider EDI Contact Person: _____   21) Phone/Ext:(____) _____/_____

22) FAX :(____) _____   23) Email Address: _____

_____   _____
24) Provider Representative's Signature (must be original)   25) Date Signed

_____
26) Provider Representative's Name – Please Print

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

Submitter Name: _____   Submitter #: _____

SECTION 3: PROVIDER SOFTWARE VENDOR INFORMATION

This section is to identify the third party software vendor practice management system that the provider is using to exchange information with their third party billing service.

27) SOFTWARE VENDOR NAME: _____

28) STREET ADDRESS: _____
   (P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the software vendor.)

29) CITY, STATE, ZIP CODE: _____

30) SOFTWARE CONTACT PERSON: _____   31) PHONE/EXT:(____) _____ / _____

32) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

33) 2nd SOFTWARE CONTACT PERSON: _____   34) PHONE/ EXT:(____) _____ / _____

35) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

36) FAX :(____) _____

37) SOFTWARE PRODUCT NAME: _____

38) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: _____

39) SOFTWARE PRODUCT RELEASE DATE: _____

*** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. ***

Return the completed EDI Agreement to Gainwell Technologies at the following address:

<table>
<tr><td align="center"><u>Via U.S. Mail</u>
EDI Unit
Gainwell Technologies
P.O. Box 4804
Trenton, New Jersey 08650 – 4804</td><td align="center"><u>Other Carriers</u>
EDI Unit
Gainwell Technologies
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619</td></tr>
</table>

4.3   New Jersey Pharmacy Submitter EDI Agreement (Form NCPDP-101) - Instructions

WHO SHOULD COMPLETE THIS AGREEMENT?

If you currently do not have a submitter number, this agreement MUST be completed. If you are a pharmacy or a billing service who would like to submit claims directly to the switch vendor, by completing this form, a submitter number will be assigned in order to submit NCPDP D.0 or 1.2 formatted claims.

SECTION 1: SUBMITTER INFORMATION

1. **New Jersey Medicaid Pharmacy Provider Number:** Enter the New Jersey Medicaid Pharmacy Provider number assigned to the provider by Gainwell Technologies.

2. **Pharmacy NPI Number:** Enter the NPI number of the Pharmacy as assigned by NPPES and registered with Gainwell Technologies.

3. **Submitter Name**: Enter the name of the Pharmacy or Billing Service Name as registered with New Jersey Medicaid/Gainwell Technologies.

4. **Submitter Street Address**: Enter the physical street address of the Pharmacy or Billing Service. This MUST be a physical address. If a P.O. Box is entered in this area, the document will be rejected and returned for correction.

5. **City, State, Zip Code**: Enter the city, state and zip code. This MUST be part of the physical address.

6. **EDI Contact Person:** Enter the name of a person in the event Gainwell Technologies needs to contact someone from your company.

7. **Phone/Ext:** Enter the phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone.

8. **FAX:** Enter the FAX number of your place of business.

9. **Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your submitter file profile. This email address will be used to send a confirmation to acknowledge the processing of the EDI AGREEMENT and confirm your submitter profile has been updated to allow you to send TEST NCPDP D.0 or 1.2 claims.

10. **2nd EDI Contact Person:** Enter the name of a person in the event Gainwell Technologies needs to contact someone from your company.

11. **Phone/Ext:** Enter the secondary phone number along with the extension of a person from your company in the event Gainwell Technologies needs to contact someone.

12. **2nd EDI Contact Person Email Address**: Enter the email address. **PLEASE PRINT CLEARLY.** This should be a business email address. This email address will be entered as part of your submitter file profile. This email address will be used to send a confirmation to acknowledge the processing of the EDI AGREEMENT and confirm your submitter profile has been updated to allow you to send TEST NCPDP D.0 or 1.2 claims.

13. **Submitter Representative's Signature**: This MUST be an actual signature of the pharmacy owner or Billing Service. THIS MAY NOT BE STAMPED. This person should have liability authority of the business.

14. **Date Signed**: Date signature was placed on this form.

15. **Submitter Representative's Name**: PLEASE PRINT CLEARLY and LEGIBLY the person's name who signed this form (Item# 11 above).

SECTION 2: NCPDP TRANSACTIONS	Please Identify the transactions you intend to submit to Gainwell Technologies.

16. **Transaction Sets:**   Please check appropriate version. If you plan on testing both real-time POS NCPDP D.0 and Batch version 1.2, then check both boxes.

SECTION 3: SOFTWARE VENDOR INFORMATION

NOTE:

- *Software information provided in this section is to be limited to the software products that will support either the NCPDP D.0 and/or the NCPDP 1.2 transaction sets.*

- *If you are a Clearing House/Billing Service and you are using an in house product that was developed by your company, this section is still required.*

- *If you are a Provider submitting claims directly to the Switch Vendor this section must be completed.*

17. **SOFTWARE VENDOR NAME:** Enter the BUSINESS name of the software vendor.

18. **STREET ADDRESS:** Enter the physical street address of the software vendor. This MUST be a physical address. If a P. O. Box is entered in this area, the document will be rejected and returned for correction.

19. **CITY, STATE, ZIP CODE:** Enter the city, state and zip code. This **MUST** be part of the physical address.

20. **SOFTWARE CONTACT PERSON:** Enter the name of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

21. **PHONE/EXT:** Enter the phone number along with the extension of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

22. **SOFTWARE CONTACT PERSON EMAIL ADDRESS:** Enter the email address of a contact person from the software company in the event Gainwell Technologies needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

23. **2nd SOFTWARE CONTACT PERSON:** Enter the name of a secondary person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

24. **PHONE/EXT:** Enter a secondary phone number along with the extension of a person from the software company in the event Gainwell Technologies needs to contact someone at the software company.

25. **2nd SOFTWARE CONTACT PERSON EMAIL:** Enter the email address of a second contact person from the software company in the event Gainwell Technologies needs to contact someone at the software company to correspond with for updates, changes, problems, etc., with software.

26. **FAX:** Enter the FAX number of the software company.

27. **SOFTWARE PRODUCT NAME:** If a software company has multiple products, please enter the name of the product you are installing for NCPDP D.0/1.2.

28. **SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME:** Please enter the release number of the software product you are installing for NCPDP D.0/1.2**.**

29. **SOFTWARE PRODUCT RELEASE DATE:** Please enter the release date of the software product you are installing for NCPDP D.0/1.2**.**

SECTION 4: SWITCH VENDOR	Identify the switch vendor(s) being used to submit claims to Gainwell Technologies

30. **Switch Vendor:** Please identify the switch vendor(s) being used to submit claims to Gainwell Technologies. If you are using one primary switch vendor and occasionally use a secondary switch vendor, please indicate by using a 1 for the Primary and 2 for the Secondary.

Return the completed EDI Agreement to Gainwell Technologies at the following address:

<table>
<tr><td align="center"><u>Via U.S. Mail</u>
EDI Unit
Gainwell Technologies
P.O. Box 4804
Trenton, New Jersey 08650 – 4804</td><td align="center"><u>Other Carriers</u>
EDI Unit
Gainwell Technologies
3705 Quakerbridge Road, Suite 101
Trenton, New Jersey 08619</td></tr>
</table>

state of newjersey

PHARMACY SUBMITTER EDI AGREEMENT

SECTION 1: SUBMITTER INFORMATION

Every Pharmacy Submitter, as a condition for submitting electronic pharmacy claim transactions to New Jersey Medicaid, **MUST** complete, sign and submit this New Jersey Pharmacy Submitter EDI Agreement to the New Jersey Medicaid Program or their designated agent.   A submitter is defined as either 1) a third party billing service who has entered into a contract with one or more New Jersey Medicaid providers to submit claims to New Jersey Medicaid on behalf of the provider or 2) a New Jersey Medicaid provider that will be submitting their claims directly to New Jersey Medicaid rather than through a third party billing service. By signing this agreement you are certifying that the claim transactions you submit will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of software services provided, and to furnish information for such services as the State agency may request.

All services will be furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Standards of Privacy of Individual Identifiable Health Information, the Electronic Transactions Standards and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 as enacted, promulgated and amended from time to time. I understand that payment and satisfaction of all claims will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

1) New Jersey Medicaid Pharmacy Provider Number:_____

2) Pharmacy Provider NPI Number:_____

3) Submitter Name:_____

4) Submitter Street Address:_____
   (P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

5) City, State, Zip Code:_____

6) EDI Contact Person:_____ 7) Phone/Ext:(_____) _____/_____

8) FAX :(_____) _____ 9) Email Address: _____

10) 2nd EDI Contact Person:_____ 11) Phone/ Ext:(_____) _____/_____

12) 2nd EDI Contact Person Email Address:_____

13) Submitter Representative's Signature (must be original)   14) Date Signed

15) (Submitter Representative's Name – Please Print)

NOTICE: Anyone who misrepresents or falsifies essential information requested by these claims (or in the electronically produced data) may upon conviction be subject to fine and imprisonment under "State and Federal Law".

gainwell

Provider Name: _____   Provider #: _____

SECTION 2: NCPDP TRANSACTIONS	Please Identify the transactions you intend to submit to Gainwell Technologies.

16) Transaction Sets: ☐ Version D.0 Telecom (real time)   ☐ Version 1.2 Batch

SECTION 3: SOFTWARE VENDOR INFORMATION

This section is to identify third party software vendor and software product information if you are using a third party software product for the actual creation and submission of transactions to New Jersey Medicaid. If you are using software capabilities that were developed in house, please enter your company name followed by "In House" in the Software Vendor Name field.

17) SOFTWARE VENDOR NAME: _____

18) STREET ADDRESS: _____
    (P.O. Boxes not accepted. Agreement will be rejected and returned if P.O. Box is listed. This must be the physical street address of the submitter.)

19) CITY, STATE, ZIP CODE: _____

20) SOFTWARE CONTACT PERSON: _____   21) PHONE/EXT:(_____) _____ / _____

22) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

23) 2nd SOFTWARE CONTACT PERSON: _____   24) PHONE/EXT:(_____) _____ / _____

25) SOFTWARE CONTACT PERSON EMAIL ADDRESS: _____

26) FAX :(_____) _____

27) SOFTWARE PRODUCT NAME: _____

28) SOFTWARE PRODUCT VERSION/RELEASE NUMBER/NAME: _____

29) SOFTWARE PRODUCT RELEASE DATE: _____

SECTION 4: SWITCH VENDOR	Identify the switch vendor(s) being used to submit claims to Gainwell Technologies

30) Switch Vendor: (Enter 1 for Primary and 2 for Secondary)

☐ Emdeon (including eRX Network)

☐ QS/1 Data Systems

☐ Relay Health

*** PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS. ***

Return the completed EDI Agreement to Gainwell Technologies at the following address:

Via U.S. Mail	**Other Carriers**
EDI Unit	**EDI Unit**
Gainwell Technologies	**Gainwell Technologies**
P.O. Box 4804	**3705 Quakerbridge Road, Suite 101**
Trenton, New Jersey 08650 – 4804	**Trenton, New Jersey 08619**

Section 5   Submitter EDI Update Form (Form EDI-301)

It is very important that Gainwell Technologies always have the current address and contact information on file for the EDI Submitter. This information is necessary for a variety of reasons:

- It can be necessary for the submitter to be contacted in the event there is an issue with the submitter's electronic claim submission, or
- confirmation on their EDI enrollment, or
- In the event we need to communicate changes to the electronic requirements

Submitters must notify Gainwell Technologies in writing when the Submitter's address or contact information changes. The Submitter must complete a Submitter EDI Update Form and submit it to Gainwell Technologies. Failure to do so can result in the suspension of the Submitter's EDI privileges.

Some common reasons EDI privileges would be suspended are:

- US Mail being returned to Gainwell Technologies
- Email address is undeliverable
- Phone contact: Phone has been disconnected.

The form is located in the public area of the NJMMIS Web site www.njmmis.com.

5.1   Instructions for accessing the Submitter EDI Update Form (Form EDI-301)

- Access the New Jersey Medicaid website at www.njmmis.com
- Under the **Information** Tab located on the lower left hand side of your screen, click on **Forms & Documents**
- For the **Choose a Type** field you want to select the value of **All**
- For the **Choose a Topic** field you want to select the value of **HIPAA**
- Click on the **Submit Request** button
- Click on the document titled **EDI-301 Submitter EDI Update Form**.

See the following page for a copy of the Submitter EDI Update Form.

state of new jersey

DOCTYPE: EMCAGREE

gainwell

SUBMITTER EDI UPDATE FORM

USE THIS FORM TO REPORT ANY CHANGES TO THE CONTACT INFORMATION ON OUR RECORDS

SUBMITTER NUMBER: _____ *(NOT TAX ID)*   EFFECTIVE DATE: _____

SUBMITTER ADDRESS *(Location from which EDI files are sent, do not use P.O. Box)*

NAME: _____

ADDRESS: _____

_____

CITY: _____

STATE: _____   ZIP: _____

SUBMITTER CONTACT NAME: _____
(Primary Person)

SUBMITTER CONTACT PHONE #: _____   EXT: _____

FAX #: _____

E-MAIL ADDRESS: _____
Note: If two e-mail addresses are entered there may only be a maximum of 58 characters

ADDITIONAL CONTACT NAME: _____

ADDITIONAL CONTACT PHONE #: _____   EXT: _____

E-MAIL ADDRESS: _____
Note: If two e-mail addresses are entered there may only be a maximum of 58 characters

If you have a separate ENROLLMENT DEPARTMENT for notification of when a provider is linked to your SUBMITTER ID, please indicate it here:

ENROLLMENT CONTACT NAME: _____

ENROLLMENT CONTACT PHONE #: _____   EXT: _____

E-MAIL ADDRESS:
(Primary)   *Note: If two e-mail addresses are entered there may only be a maximum of 58 characters*

E-MAIL ADDRESS:
(Secondary)   *Note: If two e-mail addresses are entered there may only be a maximum of 58 characters*

COMMENTS: _____
_____
_____
_____
_____

_____   _____
SIGNATURE   DATE

RETURN TO:	GAINWELL TECHNOLOGIES	
	EDI UNIT	
	P.O. BOX 4804	
EDI-301	TRENTON, NJ 08650-4804 FAX: 1-609-584-8268	November 2023

Section 6   NCPDP D.0 Claim Specifications

6.1   Claim Transaction Format

General Information:

All numeric fields are to be right justified by the software vendor. All alpha-numeric fields are to be left justified by the software vendor.

Billing and Reversal transactions will be accepted. The following transactions will not be accepted:

- Eligibility, Prior Authorization, Information Reporting, or Controlled Substance transactions.

- The Rebill transaction is only accepted from LTC pharmacies.

6.2   Transaction Specifications

Each incoming NCPDP D.0/1.2 transaction initiated by the switch vendor and each response NCPDP D.0/1.2 transaction returned to the switch vendor by Gainwell Technologies must be preceded by the following three field, sixteen (16) character string defined as "NNNXXXXXXUUUUUUU" where:

NNN constitutes the three (3) character Switch Identification assigned to the switch vendor by Gainwell Technologies. This field must be set by the switch vendor on the incoming transaction and will be returned to the switch vendor in the corresponding response transaction.

XXXXXX constitutes the six (6) character transaction identifier assigned to the transaction by the network vendor. The same transaction identifier, which originates from the switch vendor, will be returned to the switch vendor in the corresponding response.

UUUUUUU constitutes the seven (7) character field which is currently unused and can be left blank. The contents sent in this field by the switch vendor may or may not be returned to the switch vendor in the corresponding response.

The above 16 characters are found prior to the 101-A1 BIN Number (i.e., "610515") for incoming transactions and prior to the 102-A2 Version/Release Number field (i.e., the "D0") for responses.

6.3   Medicare Part D Special Requirements:

The NJ Specific Requirements section for each field will reference "PART-D" when listing specifications for claims being submitted to New Jersey for Medicare Part D coverage claims.

Field 101-A1 BIN Number

You are to continue to use the existing BIN Number of 610515 on all transactions submitted to Gainwell Technologies for processing.

Field 104-A4 Processor Control Number

You are to continue to populate this field with the previously communicated Processor Control Number values when submitting claims that were submitted to and approved by the Medicare PDP (Prescription Drug Plan) and the claim is now being submitted to New Jersey for consideration of the outstanding Medicare Part D patient deductible and/or coinsurance/co-payment responsibility. These PCN (Processor Control Number) values are required by Medicare Part D to enable tracking of out-of-pocket payments made on behalf of the

Medicare Part D beneficiary. Please refer to the February 2010 Medicaid Alert Number MA-2010-01 on the NJMMIS Web site www.njmmis.com.

- When submitting a Part D COB (Coordination Of Benefits) claim for a beneficiary enrolled in either the State's Prescription Drug Program for the Aged and Disabled (PAAD) or the State's Senior Gold prescription drug program, you are to submit the claim with a Processor Control Number of PAAD.

- When submitting a Part D COB claim for a beneficiary enrolled in the State's AIDS Drug Distribution Program (ADDP), you are to submit the claim with a Processor Control Number of ADDP.

- When submitting a Part D COB claim for a beneficiary enrolled in other than the State's Prescription Drug Program for the Aged and Disabled (PAAD), the State's Senior Gold prescription drug program, or the State's AIDS Drug Distribution Program (ADDP), you are to submit the claim with a Processor Control Number of SUPPNJ.

- When submitting a claim for beneficiaries that are not enrolled in Medicare Part D and claims where New Jersey is being billed as the primary payer because Medicare Part D has denied coverage on the claim you are to submit the claim with a Processor Control Number that is equal to ten (10) spaces.

Field 110-AK Software Vendor/Certification ID

The first three positions of this field must contain the value of NJP. Starting in position four of this field, you are to report the seven-digit EDI Submitter ID that has been assigned to you by Gainwell Technologies. This EDI Submitter ID is the certification ID that Gainwell Technologies uses to confirm that you have been certified for the submission of electronic claims.

6.4 Special Requirements:

The following tables outline the NCPDP segment and field specifications for submitting NCPDP transactions to New Jersey Medicaid.

The **Format** column in the tables below indicates the Data Element Types and their length as defined by the national standard. The **Usage** column in the tables below indicates whether the presence of the data element is mandatory or optional. The legend below indicates what the symbols in these columns represent.

Format / Usage Legend	
Symbol	**Meaning**
X	Indicates the element is alphanumeric
9	Indicates the element is numeric
s9	Indicates the element as being sighed numeric
v99	Indicates decimal point and number of decimals following decimal point
(##)	Indicates maximum length of the data element
M	Indicates that the data element is Mandatory
O	Indicates that the data element is Optional

The **NJ Specific Requirement** column indicates when there is a requirement specific to New Jersey Medicaid and other state benefit programs, which supplements the national standard. No entry in this column indicates the standard is followed.

Field	Field Name	Format	Usage	NJ Specific Requirement
TRANSACTION HEADER SEGMENT				**Required**
101-A1	BIN Number	9(06)	M	Must be 610515
102-A2	Version/Release Number	X(02)	M	Must be D0 (Dzero)
103-A3	Transaction Code	X(02)	M	B1 = Billing B3 = Rebill (valid only for return-to-stock of unit dose medications for LTC Pharmacies) Note: B2 = Reversal (Void) see Section 7 NCPDP D.0 Reversal Specifications
104-A4	Processor Control Number	X(10)	M	See NJ Specific Requirements for field 104-A4 Processor Control Number in Section 6.2 Medicare Part D Special Requirements above for additional information. Ten Spaces = Beneficiaries not enrolled in Medicare Part D and claims where New Jersey is being billed as the primary payer because Medicare Part D has denied coverage on the claim. *Continued on next page*

Field	Field Name	Format	Usage	NJ Specific Requirement
104-A4	Processor Control Number *(continued)*	X(10)	M	PAAD = Beneficiaries enrolled in New Jersey's Prescription Drug Program for the Aged and Disabled (PAAD) Program or New Jersey's Senior Gold Program ADDP = Beneficiaries enrolled in New Jersey's AIDS Drug Distribution (ADDP) Program SUPPNJ = Beneficiaries enrolled in <u>other than</u> New Jersey's (PAAD), Senior Gold or (ADDP) Prescription Drug Programs
109-A9	Transaction Count	X(01)	M	
202-B2	Service Provider ID Qualifier	X(02)	M	Must be 01 = National Provider Identifier (NPI)
201-B1	Service Provider ID	X(15)	M	Enter 10-digit National Provider Identifier (NPI)
401-D1	Date of Service	9(08)	M	YYYYMMDD
110-AK	Software Vendor/Certification ID	X(10)	M	NJP+7 digit submitter number e.g. NJP1234567
AM01	**PATIENT SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	01
331-CX	Patient ID Qualifier	X(02)	O	
332-CY	Patient ID	X(20)	O	
304-C4	Date of Birth	9(08)	M	YYYYMMDD
305-C5	Patient Gender Code	9(01)	M	1 = Male, 2 = Female
310-CA	Patient First Name	X(12)	M	Enter full first name of beneficiary
311-CB	Patient Last Name	X(15)	M	Enter full last name of beneficiary
322-CM	Patient Street Address	X(30)	O	
323-CN	Patient City Address	X(20)	O	
324-CO	Patient State / Province Address	X(02)	O	
325-CP	Patient Zip/Postal Zone	X(15)	O	
326-CQ	Patient Phone Number	9(10)	O	
307-C7	Place Of Service	9(02)	O	
333-CZ	Employer ID	X(15)	O	
335-2C	Pregnancy Indicator	X(01)	O	1 = Non Pregnant, 2 = Pregnant

384-4X	Patient Residence	9(02)	M	00 = Not Specified
				01 = Home
				02 = Skilled Nursing Facility
				    For Medicare Part B use only
				03 = Nursing Facility
				    <u>To be used for Nursing Homes</u>
				04 = Assisted Living Facility
				    <u>To be used for Assisted Living Facilities</u>
				05 = Custodial Care Facility
				    For Medicare Part B use only
				06 = Group Home
				09 = Intermediate Care Facility/Mentally Retarded
				11 = Hospice
				15 = Correctional Institution

Field	Field Name	Format	Usage	NJ Specific Requirement
AM02	**PHARMACY PROVIDER SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	O	02
465-EY	Provider ID Qualifier	X(02)	O	
444-E9	Provider ID	X(15)	O	
AM03	**PRESCRIBER SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	03
466-EZ	Prescriber ID Qualifier	X(02)	M	01 = National Provider Identifier (NPI)
411-DB	Prescriber ID	X(15)	M	Enter the 10-digit National Provider Identifier (NPI)
427-DR	Prescriber Last Name	X(15)	O	
498-PM	Prescriber Phone Number	9(10)	O	
468-2E	Primary Care Provider ID Qualifier	X(02)	O	
421-DL	Primary Care Provider ID	X(15)	O	
470-4E	Primary Care Provider Last Name	X(15)	O	
364-2J	Prescriber First Name	X(12)	O	
365-2K	Prescriber Street Address	X(30)	O	
366-2M	Prescriber City Address	X(20)	O	
367-2N	Prescriber State/Province Address	X(02)	O	
368-2P	Prescriber Zip/Postal Zone	X(15)	O	
AM04	**INSURANCE SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	04
302-C2	Cardholder ID	X(20)	M	Enter the 16-digit number on the Health Benefits ID card or the first 10 digits of the Beneficiary ID (see 303-C3).
312-CC	Cardholder First Name	X(12)	O	
313-CD	Cardholder Last Name	X(15)	O	
314-CE	Home Plan	X(03)	O	
524-FO	Plan ID	X(08)	O	
309-C9	Eligibility Clarification Code	9(01)	O	
301-C1	Group ID	X(15)	O	Omit or leave blank
303-C3	Person Code	X(03)	M	When using the card control number from the Health Benefits ID card, leave blank, otherwise enter the last 2 digits of the Beneficiary ID.
306-C6	Patient Relationship Code	9(01)	O	
359-2A	Medigap ID	X(20)	O	
360-2B	Medicaid Indicator	X(02)	O	
361-2D	Provider Accept Assignment Indicator	X(01)	O	
997-G2	CMS Part D Defined Qualified Facility	X(01)	O	
115-N5	Medicaid ID Number	X(20)	O	Enter the 7-digit NJ Medicaid Provider ID

COB/Other Payments Segment

Required if the beneficiary is covered by another payer.

New Jersey, as a government agency, is the payer of last resort and will continue to require the submission of a COB/Other Payments Segment for each insurer to whom the claim has been submitted prior to the submission of the claim to the State of New Jersey, without exception. If we have knowledge of insurance resources that include drug coverage and a COB segment is not present on the incoming claim for each of the known insurance resources, then payment on your claim will be denied. When the insurance coverage is Medicare Part D, we expect the COB segment reflecting the adjudication by the Medicare Part D processor. Failure to include the COB segment on any claim for a Medicare Part D enrolled beneficiary for a drug product that is Medicare Part D covered by statute will result in the denial of your claim.

Field 472-6E Other Payer Reject Code

When the COB segment being provided reflects Medicare Part D or private insurance, it is essential that you include on the transaction all reject codes returned to you. These codes will be used to determine if New Jersey will accept primary payer responsibility on a claim for a Medicare Part D enrolled beneficiary for a drug product that is deemed to be a Medicare Part D covered benefit by statute. The only codes that you are to report in this field are the reject codes that are returned to you by the health plan/insurer. Do not augment this list of reject codes.

Field	Field Name	Format	Usage	NJ Specific Requirement
AM05	COB/OTHER PAYMENTS SEGMENT			*Required if beneficiary is covered by another payer.*
111-AM	Segment Identification	X(02)	M	05
337-4C	Coordination of Benefits/Other Payments Count	9(02)	O	1, 2, 3 A maximum of 3 occurrences is supported
338-5C	Other Payer Coverage Type	X(02)	M	Blank = Not Specified 01 = Primary – First 02 = Secondary – Second 03 = Tertiary – Third 04 = Quaternary – Fourth
339-6C	Other Payer ID Qualifier	X(02)	M	Must be 99
340-7C	Other Payer ID	X(10)	M	Values Provided by the State of New Jersey. Mandatory for claims with other insurance; 3-character code identifies the other insurance Pharmacy Benefit Manager (PBM): Private TPL *(Not Part D):* ADV = Advance PCS AET = Aetna/USHC CAR = CareMark CIG = Cigna EXP = Express Scripts FIR = FirstHealth PAI = PAID NPA = NPA PCS = PCS PRO = ProServ RES = Restat TRI = TriCare *Continued on next page*

Field	Field Name	Format	Usage	NJ Specific Requirement
340-7C	Other Payer ID *(continued)*	X(10)	M	UHS = United Health WEL = Well Point OTH = Other PART-D: Medicare C Plans CAP = Aetna US Healthcare PPO CAE = Aetna US Healthcare CAM = Americhoice CAH = Amerihealth 65 CEC = Evercare Choice CHO = Horizon Healthcare NJ COX = Oxford Health Plans NJ CUH = United Healthcare MED = Part C Other Medicare D Plans DAE = Aetna Life Insurance DAH = AmeriHealth 65 DAP = American Progressive Life and Health DBR = Bravo by Elder Care DCA = Coventry Advantra RX DCG = CIGNA DER = Envision Rx Plus DFH = First Health Premier DFX = Fox Insurance Company DHN = Health Net DHO = Horizon Healthcare DHS = HealthSpring Prescription Plan DHU = Humana DME = Medco Health Solutions DMH = Memberhealth DNM = NMHC Group Solutions DPA = Pacificare Life DPL = Pennsylvania Life DRX = RXAmerica DSA = SAMAscript DSI = SierraRx DSS = Silverscript DST = Sterling Plus RX DUA = United American DUH = United Healthcare DUN = Unicare DWE = Wellcare MED = Part D Other
443-E8	Other Payer Date	9(08)	O	
993-A7	Internal Control Number	X(30)	O	
341-HB	Other Payer Amount Paid Count	9(02)	O	
342-HC	Other Payer Amount Paid Qualifier	X(02)	O/M	Mandatory when the billing provider anticipates payment from another payer.

Field	Field Name	Format	Usage	NJ Specific Requirement
431-DV	Other Payer Amount Paid	s9(6)v99	O/M	Mandatory when the billing provider anticipates payment from another payer. LTC Rebill: Mandatory when applicable
471-5E	Other Payer Reject Count	9(02)	O	
472-6E	Other Payer Reject Code	X(03)	O/M	Mandatory if another payer rejected the claim.
353-NR	Other Payer-Patient Responsibility Amount Count	9(02)	O/M	Mandatory when claim is not rejected by another payer.
351-NP	Other Payer-Patient Responsibility Amount Qualifier	X(02)	O/M	Mandatory when claim is not rejected by another payer.
352-NQ	Other Payer-Patient Responsibility Amount	s9(8)v99	O/M	Mandatory when applicable/including Part D COB claims. Mandatory if 351-NP is present. When 351-NP = 09 the amount must be submitted as negative value or zero.
392-MU	Benefit Stage Count	9(02)	O/M	Mandatory for PART D approved claims.
393-MV	Benefit Stage Qualifier	X(02)	O/M	Mandatory for PART D approved claims.
394-MW	Benefit Stage Amount	s9(6)v99	O/M	Mandatory if 393-MV is present.
AM06	**WORKERS' COMPENSATION SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	06
434-DY	Date Of Injury	9(08)	M	
315-CF	Employer Name	X(30)	O	
316-CG	Employer Street Address	X(30)	O	
317-CH	Employer City Address	X(20)	O	
318-CI	Employer State/Province Address	X(02)	O	
319-CJ	Employer Zip/Postal Zone	X(15)	O	
320-CK	Employer Phone Number	9(10)	O	
321-CL	Employer Contact Name	X(30)	O	
327-CR	Carrier ID	X(10)	O	
435-DZ	Claim/Reference ID	X(30)	O	
117-TR	Billing Entity Type Indicator	9(02)	O	
118-TS	Pay To Qualifier	X(02)	O	
119-TT	Pay To ID	X(15)	O	
120-TU	Pay To Name	X(20)	O	
121-TV	Pay To Street Address	X(30)	O	
122-TW	Pay To City Address	X(20)	O	
123-TX	Pay To State/Province Address	X(02)	O	
124-TY	Pay To Zip/Postal Zone	X(15)	O	
125-TZ	Generic Equivalent Product ID Qualifier	X(02)	O	
126-UA	Generic Equivalent Product ID	X(19)	O	
AM07	**CLAIM SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	07
455-EM	Prescription/Service Reference Number Qualifier	X(01)	M	Must be 1 = RX Billing
402-D2	Prescription/Service Reference Number	9(12)	M	If Prescription Number is less than 12 positions it must be left zero filled so as to provide a 12-digit value. (e.g. If Pharmacy's Rx # is 7 digits it must be submitted as 000001234567) Plan B ® OTC claims enter a 12-digit Service Reference Number, left zero filled.
436-E1	Product/Service Id Qualifier	X(02)	M	Must be 03 (Must be 00 for Compound claims)
407-D7	Product/Service Id	X(19)	M	11-digit NDC (compounds 11 zeros or 1 zero)

Field	Field Name	Format	Usage	NJ Specific Requirement
456-EN	Associated Prescription/Service Reference #	9(12)	O	
457-EP	Associated Prescription/Service Date	9(08)	O	
458-SE	Procedure Modifier Code Count	9(02)	O	
459-ER	Procedure Modifier Code	X(02)	O	
442-E7	Quantity Dispensed	9(7)v999	M	LTC Rebill: Report actual metric quantity of service units administered. If all units are being recycled report "0" (zero).
403-D3	Fill Number	9(02)	M	Up to 2 digits
405-D5	Days Supply	9(03)	M	Up to 3 digits
406-D6	Compound Code	9(01)	M	Valid values are 1 (non-compound) or 2 (compound)
408-D8	Dispense As Written (DAW)/Product Selection Code	X(01)	M	0 = not dispensed as written 1 = dispense as written 2 to 9 = Not Applicable
414-DE	Date Prescription Written	9(08)	M	YYYYMMDD
415-DF	Number Of Refills Authorized	9(02)	M	
419-DJ	Prescription Origin Code	9(01)	O	
354-NX	Submission Clarification Code Count	9(02)	O/M	Mandatory when 420-DK is present.
420-DK	Submission Clarification Code	9(02)	O/M	08 = Acceptable for compound claims as applicable 02 = Acceptable for first dose of vaccine claim. 06 = Acceptable for second dose of vaccine claim 07 = Acceptable for additional or booster dose of COVID19 vaccine 10 = Acceptable for booster dose of COVID19 vaccine Note: Until further notice, please submit only 07 for additional dose of COVID19 vaccine, and 07 and 10 for booster dose of COVID19 vaccine. Note: Effective 9/11/2023, claims for the new COVID vaccine NDCs will not require a Submission Clarification Code.
308-C8	Other Coverage Code	9(02)	M	00 = Not specified; pharmacist unaware of insurance coverage 01 = No other coverage; Pharmacist unaware of insurance coverage 02 = Other coverage exists – payment collected, TPL payment reported on claim 03 = Other coverage exists – claim not covered; drug product not covered by carrier 04 = Other coverage exists – payment not collected i.e., other insurance claim can not be processed electronically *Continued on next page*

Field	Field Name	Format	Usage	NJ Specific Requirement
308-C8	Other Coverage Code *(continued)*	9(02)	M	08 = Claim is billing for copay; payment reflects 100% copayment Note: COB/Other Payments segment is mandatory when other coverage exists.
429-DT	Special Packaging Indicator	9(01)	O	
453-EJ	Originally Prescribed Product/Service ID Qualifier	X(02)	O	
445-EA	Originally Prescribed Product/Service Code	X(19)	O	
446-EB	Originally Prescribed Quantity	9(7)v999	O	
600-28	Unit Of Measure	X(02)	M	EA = each, GM = grams, and ML = Milliliters
418-DI	Level Of Service	9(02)	O	
460-ET	Quantity Prescribed	9(7)v999	M	
461-EU	Prior Authorization Type Code	9(02)	M	00 = No PA number 01 = PA number entered 05 = Exemption from Rx (i.e. Nonparticipating pharmacy in other insurance provider network)
462-EV	Prior Authorization Number Submitted	9(11)	O	Enter the 10-digit PA number in 11 digit field entering 0 in first position of field
463-EW	Intermediary Authorization Type ID	9(02)	O	
464-EX	Intermediary Authorization ID	X(11)	O	
343-HD	Dispensing Status	X(01)	O	Value with "P" for partial fill; "C" for completion of a previous partial fill; blank if neither.
344-HF	Quantity Intended To Be Dispensed	9(7)v999	O	Mandatory for partial fill or completion of previous paid partial fill. Must be greater than 442- E7 when 343-HD = "P" or "C".
345-HG	Days Supply Intended To Be Dispensed	9(03)	O	Mandatory for partial fill or completion of previous paid partial fill. Must be greater than 405- D5 when 343-HD = "P" or "C".
357-NV	Delay Reason Code	9(02)	O	
391-MT	Patient assignment Indicator (Direct Member Reimbursement Indicator)	X(01)	O	
995-E2	Route of Administration	X(11)	O	
996-G1	Compound Type	X(02)	O	
147-U7	Pharmacy Service Type	9(02)	O	
AM08	**DUR (Drug Utilization Review)/PPS (Professional Pharmacy Service) SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	08
473-7E	DUR/PPS Code Counter	9(02)	O	1, 2, 3…9 A maximum of 9 is supported
439-E4	Reason For Service Code	X(02)	O	
440-E5	Professional Service Code	X(02)	O	Mandatory for Vaccine Admin submission. Value with "MA" (Medication Administration)
441-E6	Result Of Service Code	X(02)	O	
474-8E	DUR/PPS Level Of Effort	X(02)	O	
475-J9	DUR Co-Agent ID Qualifier	9(02)	O	
476-H6	DUR Co-Agent ID	X(02)	O	

Field	Field Name	Format	Usage	NJ Specific Requirement
AM09	**COUPON SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	O	09
485-KE	Coupon Type	X(02)	O	
486-ME	Coupon Number	X(15)	O	
487-NE	Coupon Value Amount	s9(6)v99	O	
AM10	**COMPOUND SEGMENT**			**Required On Claims For Compound Drugs**
111-AM	Segment Identification	X(02)	M	10
450-EF	Compound Dosage Form Description Code	X(02)	M	Enter values 01 - 18
451-EG	Compound Dispensing Unit Form Indicator	9(01)	M	1 = Each 2 = Gram 3 = Milliliter
447-EC	Compound Ingredient Component Count	9(02)	M	1, 2,…24, 25 A maximum of 25 ingredients will be accepted. Identifies the ingredient within a compound (i.e. Ingredient Number 12)
488-RE	Compound Product Id Qualifier	X(02)	M	Must be 03
489-TE	Compound Product Id	X(19)	M	Enter 11-digit NDC
448-ED	Compound Ingredient Quantity	9(7)v999	M	
449-EE	Compound Ingredient Drug Cost	s9(6)v99	M	
490-UE	Compound Ingredient Basis Of Cost Determination	X(02)	O	
362-2G	Compound Ingredient Modifier Code Count	9(2)	O	
363-2H	Compound Ingredient Modifier Code	X(02)	O	
AM11	**PRICING SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	11
409-D9	Ingredient Cost Submitted	s9(6)v99	M	Value entered must be greater than 0.
412-DC	Dispensing Fee Submitted	s9(6)v99	O	
433-DX	Patient Paid Amount Submitted	s9(6)v99	N/A	Not valid in D.0. Use fields 351-NP and 352-NQ instead.
438-E3	Incentive Amount Submitted	s9(6)v99	O	Incentive Amount Submitted – Mandatory when 440-E5 submitted with "MA".
478-H7	Other Amount Claimed Submitted Count	9(02)	O	
479-H8	Other Amount Claimed Submitted Qualifier	X(02)	O	
480-H9	Other Amount Claimed Submitted	s9(6)v99	O	
481-HA	Flat Sales Tax Amount Submitted	s9(6)v99	O	
482-GE	Percentage Sales Tax Amount Submitted	s9(6)v99	O	
483-HE	Percentage Sales Tax Rate Submitted	s9(3)v9(4)	O	
484-JE	Percentage Sales Tax Basis Submitted	X(02)	O	
426-DQ	Usual And Customary Charge	s9(6)v99	M	Provider usual and customary charge. For compounds, report usual and customary charge for entire compound.
430-DU	Gross Amount Due	s9(6)v99	M	Value entered must be greater than 0.

Field	Field Name	Format	Usage	NJ Specific Requirement
423-DN	Basis Of Cost Determination	X(02)	M	Mandatory for 340B Claims submitted for PCN SUPPNJ (for dates of service 4/1/2017 or later), or PCN ADDP (for dates of service 7/1/2017 or later), if applicable. Value with "8". For PCN PAAD, "8" is applicable for dates of service on or after 1/19/2023.
AM12	**PRIOR AUTHORIZATION SEGMENT**			**NOT ACCEPTED**
111-AM	Segment Identification	X(02)	N/A	12
498-PA	Request Type	X(01)	N/A	
498-PB	Request Period Date-Begin	9(08)	N/A	
498-PC	Request Period Date-End	9(08)	N/A	
498-PD	Basis Of Request	X(02)	N/A	
498-PE	Authorized Representative First Name	X(12)	N/A	
498-PF	Authorized Representative Last Name	X(15)	N/A	
498-PG	Authorized Representative Street Address	X(30)	N/A	
498-PH	Authorized Representative City Address	X(20)	N/A	
498-PJ	Authorized Representative State/Province Address	X(02)	N/A	
498-PK	Authorized Representative Zip/Postal Zone	X(15)	N/A	
498-PY	Prior Authorization Number--Assigned	9(11)	N/A	
503-F3	Authorization Number	X(20)	N/A	
498-PP	Prior Authorization Supporting Documentation	X(500)	N/A	
AM13	**CLINICAL SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	13
491-VE	Diagnosis Code Count	9(02)	M	1, 2, 3, 4, or 5. A maximum of 5 Diagnosis Codes will be accepted.
492-WE	Diagnosis Code Qualifier	X(02)	M	01 = International Classification of Diseases (ICD9) 02 = International Classification of Diseases-10-Clinical Modifications (ICD-10-CM) – not applicable until implemented in 2015. Claims will not be accepted with a mixture of ICD-9 and ICD-10-CM codes. For service dates before 10/1/2015 use "01", for service dates on or after 10/1/2015 use "02".
424-DO	Diagnosis Code	X(15)	O	Enter the appropriate diagnosis code. If the value entered in the Diagnosis Code Qualifier field is equal to "01", then the diagnosis code entered must be an ICD-9 diagnosis code. If the value entered in the Diagnosis Code Qualifier field is equal to "02", then the diagnosis code entered must be an ICD-10 diagnosis code.
493-XE	Clinical Information Counter	9(02)	O	

Field	Field Name	Format	Usage	NJ Specific Requirement
494-ZE	Measurement Date	9(08)	O	
495-H1	Measurement Time	9(04)	O	
496-H2	Measurement Dimension	X(02)	O	
497-H3	Measurement Unit	X(02)	O	
499-H4	Measurement Value	X(15)	O	
AM14	**ADDITIONAL DOCUMENTATION SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	O	14
369-2Q	Additional Documentation Type ID	X(03)	O	
375-2V	Request Period Begin Date	9(08)	O	
375-2W	Request Period Recert/Revised Date	9(08)	O	
373-2U	Request Status	X(01)	O	
371-2S	Length Of Need Qualifier	9(02)	O	
370-2R	Length Of Need	9(03)	O	
372-2T	Prescriber/Supplier Date Signed	9(08)	O	
376-2X	Supporting Documentation	X(65)	O	
377-2Z	Question Number/Letter Count	9(02)	O	
378-4B	Question Number/Letter	X(03)	O	
379-4D	Question Percent Response	9(3)v99	O	
380-4G	Question Date Response	9(08)	O	
381-4H	Question Dollar Amount Response	s9(9)v99	O	
382-4J	Question Numeric Response	9(11)	O	
383-4K	Question Alphanumeric Response	X(30)	O	
AM15	**FACILITY SEGMENT**			**Optional/Mandatory for all Nursing Facility Claims**
111-AM	Segment Identification	X(02)	M	15
336-8C	Facility ID	X(10)	M	Report the LTC facility 7-digit Medicaid Provider Number.
385-3Q	Facility Name	X(30)	O/M	Mandatory if 336-8C is present
386-3U	Facility Street Address	X(30)	O	
388-5J	Facility City Address	X(20)	O	
387-3V	Facility State/Province Address	X(02)	O	
389-6D	Facility Zip/Postal Zone	X(15)	O	
AM16	**NARRATIVE SEGMENT**			**Optional**
111-AM	Segment Identification	(X02)	O	16
390-BM	Narrative Message	X(200)	O	

Section 7   NCPDP D.0 Reversal Specifications

7.1   Reversal Transactions Format

The following tables outline the NCPDP D.0 Reversal segment and field specifications for submitting NCPDP reversal (void) transactions to New Jersey Medicaid. Please do not submit segments that are not required for reversals. If segments are submitted that are not required, they will be parsed for NCPDP compliance and could result in rejected transactions.

Field 402-D2 Prescription/Service Reference Number

Previously in 5.1 the Prescription/Service Number was coded as an alphanumeric field. You were instructed to enter the value in this field to include a 7 digit prescription/service reference number, left zero filling the field if less than 12 positions. In D.0 this field has been expanded to 12 positions therefore, when submitting reversals for claims that were originally submitted in 5.1 you must now expand the previously submitted 7 position Prescription/Service Number to now be 12 digits. (e.g. if the pharmacy's 5.1 claim is being reversed had a Rx # of 1234567, the Rx # must now be submitted as 000001234567 in the D.0 format.)

Field	Field Name	Format	Usage	NJ Specific Requirement
TRANSACTION HEADER SEGMENT				**Required**
101-A1	BIN Number	9(06)	M	Must be 610515
102-A2	Version/Release Number	X(02)	M	Must be D0 (Dzero)
103-A3	Transaction Code	X(02)	M	B2 = Reversal
104-A4	Processor Control Number	X(10)	M	See NJ Specific Requirements for field 104-A4 Processor Control Number in Section 6.2 Medicare Part D Special Requirements above for additional information. Ten Spaces = Beneficiaries not enrolled in Medicare Part D and claims where New Jersey is being billed as the primary payer because Medicare Part D has denied coverage on the claim. PAAD = Beneficiaries enrolled in New Jersey's Prescription Drug Program for the Aged and Disabled (PAAD) Program or New Jersey's Senior Gold Program ADDP = Beneficiaries enrolled in New Jersey's AIDS Drug Distribution (ADDP) Program SUPPNJ = Beneficiaries enrolled in other than New Jersey's (PAAD), Senior Gold or (ADDP) Prescription Drug Programs
109-A9	Transaction Count	X(01)	M	
202-B2	Service Provider ID Qualifier	X(02)	M	Must be 01 = National Provider Identifier (NPI)
201-B1	Service Provider ID	X(15)	M	Enter 10-digit National Provider Identifier (NPI)
401-D1	Date Of Service	9(08)	M	YYYYMMDD
110-AK	Software Vendor/Certification ID	X(10)	M	NJP+7 digit submitter number e.g. NJP1234567

Field	Field Name	Format	Usage	NJ Specific Requirement
AM07	**CLAIM SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	07
455-EM	Prescription/Service Reference Number Qualifier	X(01)	M	Must be 1 = RX Billing
402-D2	Prescription/Service Reference Number	9(12)	M	See NJ Specific Requirements for field 402-D2 Prescription/Service Reference Number described above in beginning of section for additional information. If Prescription Number is less than 12 positions it must be left zero filled so as to provide a 12-digit value. (e.g. If Pharmacy's Rx # is 7 digits it must be submitted as 000001234567) Plan B ® OTC claims enter a 12-digit Service Reference Number, left zero filled.
436-E1	Product/Service ID Qualifier	X(02)	M	Must be 03 (Must be 00 for Compound claims)
407-D7	Product/Service ID	X(19)	M	11-digit NDC (compounds 11 zeros or 1 zero)
403-D3	Fill Number	9(02)	O	
308-C8	Other Coverage Code	9(02)	O	
147-U7	Pharmacy Service Type	9(02)	O	

Section 8 NCPDP D.0 Response Specifications

8.1 Accepted (Paid) Response Transactions Format

The following tables outline the NCPDP D.0 Response segment and field specifications for NCPDP accepted (paid) response transactions sent back to the pharmacy.

Field	Field Name	Format	Usage	NJ Specific Requirement
	RESPONSE HEADER SEGMENT			**Required**
102-A2	Version/Release Number	X(02)	M	Must be D0 (Dzero)
103-A3	Transaction Code	X(02)	M	B1 = Billing B3 = Rebill (valid only for return-to-stock of unit dose medications for LTC Pharmacies) Note: B2 = Reversal (Void) See page 36 for accepted reversal
109-A9	Transaction Count	X(01)	M	
501-F1	Header Response Status	X(01)	M	A = Accepted
202-B2	Service Provider ID Qualifier	X(02)	M	01 = National Provider Identifier (NPI)
201-B1	Service Provider ID	X(15)	M	10-digit National Provider Identifier (NPI)
401-D1	Date of Service	9(08)	M	YYYYMMDD
AM20	**RESPONSE MESSAGE SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	20
504-F4	Message	X(01) – X(200)	O	Will contain the unique Internal Control Number (ICN) assigned when the claim is adjudicated in real-time. The ICN must be given to the Help Desk when requesting assistance with the claim.
AM21	**RESPONSE STATUS SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	21
112-AN	Transaction Response Status	X(01)	M	P = Paid Claim
503-F3	Authorization Number	X(20)	O	
547-5F	Approved Message Code Count	9(01)	O	Up to 5.
548-6F	Approved Message Code	X(02)	O	
130-UF	Additional Message Information Count	9(02)	O	0 – 25
132-UH	Additional Message Information Qualifier	X(02)	O	
526-FQ	Additional Message Information	X(01) - X(40)	O	
131-UG	Additional Message Information Continuity	X(01)	O	
550-7F	Help Desk Phone Number Qualifier	X(02)	O	03 = Processor/PBM
550-8F	Help Desk Phone Number	X(18)	O	1-800-776-6334
993-A7	Internal Control Number	X(30)	O	
AM22	**RESPONSE CLAIM SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	22
455-EM	Prescription/Service Reference Number Qualifier	X(01)	M	1 = Rx Billing

Field	Field Name	Format	Usage	NJ Specific Requirement
402-D2	Prescription/Service Reference Number	9(12)	M	
551-9F	Preferred Product Count	9(01)	O	
552-AP	Preferred Product ID Qualifier	X(02)	O	
553-AR	Preferred Product ID	X(19)	O	
554-AS	Preferred Product Incentive	s9(6)v99	O	
555-AT	Preferred Product Cost Share Incentive	s9(6)v99	O	
556-AU	Preferred Product Description	X(40)	O	
AM23	**RESPONSE PRICING SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	23
505-F5	Patient Pay Amount	s9(6)v99	M	
506-F6	Ingredient Cost Paid	s9(6)v99	O	
507-F7	Dispensing Fee Paid	s9(6)v99	O	
557-AV	Tax Exempt Indicator	X(01)	O	
558-AW	Flat Sales Tax Amount Paid	s9(6)v99	O	
559-AX	Percentage Sales Tax Amount Paid	s9(6)v99	O	
560-AY	Percentage Sales Tax Rate Paid	s9(3)v4	O	
561-AZ	Percentage Sales Tax Basis Paid	X(02)	O	
521-FL	Incentive Amount Paid	s9(6)v99	O	Required if Incentive Amount Submitted (438-E3) is greater than zero (0).
563-J2	Other Amount Paid Count	9(01)	O	
564-J3	Other Amount Paid Qualifier	X(02)	O	
565-J4	Other Amount Paid	s9(6)v99	O	
566-J5	Other Payer Amount Recognized	s9(6)v99	O	
509-F9	Total Amount Paid	s9(6)v99	M	
522-FM	Basis of Reimbursement Determination	9(02)	O	
523-FN	Amount Attributed to Sales Tax	s9(6)v99	Q	
512-FC	Accumulated Deductible Amount	s9(6)v99	O	
513-FD	Remaining Deductible Amount	s9(6)v99	O	
514-FE	Remaining Benefit Amount	s9(6)v99	O	
517-FH	Amount Applied to Periodic Deductible	s9(6)v99	O	
518-FI	Amount of Copay	s9(6)v99	O	
520-FK	Amount Exceeding Periodic Benefit Maximum	s9(6)v99	O	
346-HH	Basis of Calculation – Dispensing Fee	X(02)	O	
347-HJ	Basis of Calculation – Copay	X(02)	O	
348-HK	Basis of Calculation – Flat Sales Tax	X(02)	O	
349-HM	Basis of Calculation – Percentage Sales Tax	X(02)	O	
571-NZ	Amount Attributed to Processor Fee	s9(6)v99	O	
575-EQ	Patient Sales Tax Amount	s9(6)v99	O	
574-2Y	Plan Sales Tax Amount	s9(6)v99	O	
572-4U	Amount of Coinsurance	s9(6)v99	O	

Field	Field Name	Format	Usage	NJ Specific Requirement
573-4V	Basis of Calculation-Coinsurance	X(02)	O	
392-MU	Benefit Stage Count	9(01)	O	
393-MV	Benefit Stage Qualifier	X(02)		
394-MW	Benefit Stage Amount	s9(6)v99	O	
577-G3	Estimated Generic Savings	s9(6)v99	O	
128-UC	Spending Account Amount Remaining	s9(6)v99	O	
129-UD	Health Plan-Funded Assistance Amount	s9(6)v99	O	
133-UJ	Amount Attributed to Provider Network Selection	s9(6)v99	O	
134-UK	Amount Attributed to Product Selection/Brand Drug	s9(6)v99	O	
135-UM	Amount Attributed to Product Selection/Non-Preferred Formulary Selection	s9(6)v99	O	
136-UN	Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection	s9(6)v99	O	
137-UP	Amount Attributed to Coverage Gap	s9(6)v99	O	
148-U8	Ingredient Cost Contracted/Reimbursable Amount	s9(6)99	O	
149-U9	Dispensing Fee Contracted/Reimbursable Amount	s9(6)99	O	
AM24	**RESPONSE DUR/PPS SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	24
567-J6	DUR/PPS Response Code Counter	9(01)	O	
439-E4	Reason for Service Code	X(02)	O	
528-FS	Clinical Significance Code	X(01)	O	
529-FT	Other Pharmacy Indicator	9(01)	O	
531-FV	Quantity of Previous Fill	9(7)v999	O	
530-FU	Previous Date of Fill	9(08)	O	
532-FW	Database Indicator	X(01)	O	
533-FX	Other Prescriber Indicator	9(01)	O	
544-FY	DUR Free Text Message	X(30)	O	
570-NS	DUR Additional Text	X(100)	O	
AM25	**RESPONSE INSURANCE SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	25
301-C1	Group ID	X(15)	O	
524-FO	Plan ID	X(08)	O	
545-2F	Network Reimbursement ID	X(10)	O	
568-J7	Payer ID Qualifier	X(02)	O	
569-J8	Payer ID	X(10)	O	
302-C2	Cardholder Id	X(20)	M	The ID returned in the response is the Beneficiary ID to be used in future Transactions. The ID on the claim is not the current ID for the patient.

Field	Field Name	Format	Usage	NJ Specific Requirement
AM28	**RESPONSE COB/OTHER PAYERS SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	28
355-NT	Other Payer ID Count	9(01)	M	
338-5C	Other Payer Coverage Type	X(02)	M	
339-6C	Other Payer ID Qualifier	X(02)	O	
340-7C	Other Payer ID	X(10)	O	
991-MH	Other Payer Processor Control Number	X(10)	O	
356-NU	Other Payer Cardholder ID	X(20)	O	
992-MJ	Other Payer Group ID	X(15)	O	
142-UV	Other Payer Person Code	X(03)	O	
127-UB	Other Payer Help Desk Phone Number	X(18)	O	
143-UW	Other Payer Patient Relationship Code	9(01)	O	
144-UX	Other Payer Benefit Effective Date	9(08)	O	
145-UY	Other Payer Benefit Termination Date	9(08)	O	
AM29	**RESPONSE PATIENT SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	29
310-CA	Patient First Name	X(12)	O	Full first name of beneficiary
311-CB	Patient Last Name	X(15)	O	Full last name of beneficiary
304-C4	Date of Birth	9(08)	O	YYYYMMDD

8.2 Rejected Response Transactions Format

The following tables outline the NCPDP D.0 Response segment and field specifications for NCPDP rejected response transactions sent back to the pharmacy.

Field	Field Name	Format	Usage	NJ Specific Requirement
	RESPONSE HEADER SEGMENT			**Required**
102-A2	Version/Release Number	X(02)	M	Must be D0 (Dzero)
103-A3	Transaction Code	X(02)	M	B1 = Billing B3 = Rebill (valid only for return-to-stock of unit dose medications for LTC Pharmacies) Note: B2 = Reversal (Void) See page 48 for rejected reversal
109-A9	Transaction Count	X(01)	M	
501-F1	Header Response Status	X(01)	M	R = Rejected
202-B2	Service Provider ID Qualifier	X(02)	M	01 = National Provider Identifier (NPI)
201-B1	Service Provider ID	X(15)	M	10-digit National Provider Identifier (NPI)
401-D1	Date of Service	9(08)	M	YYYYMMDD
AM20	**RESPONSE MESSAGE SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	20
504-F4	Message	X(01) – X(200)	O	Will contain the unique Internal Control Number (ICN) assigned when the claim is adjudicated in real-time. The ICN must be given to the Help Desk when requesting assistance with the claim.
AM21	**RESPONSE STATUS SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	21
112-AN	Transaction Response Status	X(01)	M	R = Rejected Claim or D = Duplicate Claim
503-F3	Authorization Number	X(20)	O	
510-FA	Reject Count	9(02)	M	
511-FB	Reject Code	X(03)	M	
546-4F	Reject Field Occurrence Indicator	9(02)	O	
130-UF	Additional Message Information Count	9(02)	O	Max of 25.
132-UH	Additional Message Information Qualifier	X(02)	O	
526-FQ	Additional Message Information	X(01) - X(40)	O	
131-UG	Additional Message Information Continuity	X(01)	O	
550-7F	Help Desk Phone Number Qualifier	X(02)	O	03 = Processor/PBM
550-8F	Help Desk Phone Number	X(18)	O	1-800-776-6334
987-MA	URL	X(255)	O	WWW.NJMMIS.COM
AM22	**RESPONSE CLAIM SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	22
455-EM	Prescription/Service Reference Number Qualifier	X(01)	M	1 = Rx Billing

Field	Field Name	Format	Usage	NJ Specific Requirement
402-D2	Prescription/Service Reference Number	9(12)	M	
551-9F	Preferred Product Count	9(01)	O	
552-AP	Preferred Product ID Qualifier	X(02)	O	
553-AR	Preferred Product ID	X(19)	O	
554-AS	Preferred Product Incentive	s9(6)v99	O	
555-AT	Preferred Product Cost Share Incentive	s9(6)v99	O	
556-AU	Preferred Product Description	X(40)	O	
AM24	**RESPONSE DUR/PPS SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	24
567-J6	DUR/PPS Response Code Counter	9(01)	O	
439-E4	Reason for Service Code	X(02)	O	
528-FS	Clinical Significance Code	X(01)	O	
529-FT	Other Pharmacy Indicator	9(01)	O	
531-FV	Quantity of Previous Fill	9(7)v999	O	
530-FU	Previous Date of Fill	9(08)	O	
532-FW	Database Indicator	X(01)	O	
533-FX	Other Prescriber Indicator	9(01)	O	
544-FY	DUR Free Text Message	X(30)	O	
570-NS	DUR Additional Text	X(100)	O	
AM25	**RESPONSE INSURANCE SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	25
301-C1	Group ID	X(15)	O	
524-FO	Plan ID	X(08)	O	
545-2F	Network Reimbursement ID	X(10)	O	
568-J7	Payer ID Qualifier	X(02)	O	
569-J8	Payer ID	X(10)	O	
302-C2	Cardholder Id	X(20)	M	The ID returned in the response is the Beneficiary ID to be used in future Transactions. The ID on the claim is not the current ID for the patient.
AM28	**RESPONSE COB/OTHER PAYERS SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	28
355-NT	Other Payer ID Count	9(01)	M	
338-5C	Other Payer Coverage Type	X(02)	M	
339-6C	Other Payer ID Qualifier	X(02)	O	
340-7C	Other Payer ID	X(10)	O	
991-MH	Other Payer Processor Control Number	X(10)	O	
356-NU	Other Payer Cardholder ID	X(20)	O	
992-MJ	Other Payer Group ID	X(15)	O	
142-UV	Other Payer Person Code	X(03)	O	
127-UB	Other Payer Help Desk Phone Number	X(18)	O	
143-UW	Other Payer Patient Relationship Code	9(01)	O	
144-UX	Other Payer Benefit Effective Date	9(08)	O	

Field	Field Name	Format	Usage	NJ Specific Requirement
145-UY	Other Payer Benefit Termination Date	9(08)	O	
AM29	**RESPONSE PATIENT SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	29
310-CA	Patient First Name	X(12)	O	Full first name of beneficiary
311-CB	Patient Last Name	X(15)	O	Full last name of beneficiary
304-C4	Date of Birth	9(08)	O	YYYYMMDD

8.3 Accepted Reversal Response Transactions Format

The following tables outline the NCPDP D.0 Response segment and field specifications for NCPDP reversal response transactions sent back to the pharmacy.

Field		Field Name	Format	Usage	NJ Specific Requirement
		RESPONSE HEADER SEGMENT			**Required**
	102-A2	Version/Release Number	X(02)	M	Must be D0 (Dzero)
	103-A3	Transaction Code	X(02)	M	B2 = Reversal
	109-A9	Transaction Count	X(01)	M	
	501-FI	Header Response Status	X(01)	M	A = Accepted
	202-B2	Service Provider ID Qualifier	X(02)	M	01 = National Provider Identifier (NPI)
	201-B1	Service Provider ID	X(15)	M	10-digit National Provider Identifier (NPI)
	401-D1	Date of Service	9(08)	M	YYYYMMDD
AM20		**RESPONSE MESSAGE SEGMENT**			**Optional**
	111-AM	Segment Identification	X(02)	M	20
	504-F4	Message	X(01) – X(200)	O	Will contain the unique Internal Control Number (ICN) assigned when the claim is adjudicated in real-time. The ICN must be given to the Help Desk when requesting assistance with the claim.
AM21		**RESPONSE STATUS SEGMENT**			**Required**
	111-AM	Segment Identification	X(02)	M	21
	112-AN	Transaction Response Status	X(01)	M	
	503-F3	Authorization Number	X(20)	O	
	130-UF	Additional Message Information Count	9(02)	O	
	132-UH	Additional Message Information Qualifier	X(02)	O	
	526-FQ	Additional Message Information	X(01) - X(40)	O	
	131-UG	Additional Message Information Continuity	X(01)	O	
	549-7F	Help Desk Phone Number Qualifier	X(02)	O	03 = Processor/PBM
	550-8F	Help Desk Phone Number	X(18)	O	1-800-776-6334
	993-A7	Internal Control Number	X(30)	O	
AM22		**RESPONSE CLAIM SEGMENT**			**Required**
	111-AM	Segment Identification	X(02)	M	22
	455-EM	Prescription/Service Reference Number Qualifier	X(01)	M	1 = Rx Billing
	402-D2	Prescription/Service Reference Number	9(12)	M	
AM23		**RESPONSE PRICING SEGMENT**			**Optional**
	111-AM	Segment Identification	X(02)	M	23
	521-FL	Incentive Amount Paid	s9(6)v99	O	Required if Incentive Amount Submitted (438-E3) is greater than zero (0).
	509-F9	Total Amount Paid	s9(6)v99	O	

8.4 Rejected Reversal Response Transactions Format

The following tables outline the NCPDP D.0 Response segment and field specifications for NCPDP rejected reversal response transactions sent back to the pharmacy.

Field	Field Name	Format	Usage	NJ Specific Requirement
	RESPONSE HEADER SEGMENT			**Required**
102-A2	Version/Release Number	X(02)	M	Must be D0 (Dzero)
103-A3	Transaction Code	X(02)	M	B2 = Reversal
109-A9	Transaction Count	X(01)	M	
501-FI	Header Response Status	X(01)	M	R = Rejected
202-B2	Service Provider ID Qualifier	X(02)	M	01 = National Provider Identifier (NPI)
201-B1	Service Provider ID	X(15)	M	10-digit National Provider Identifier (NPI)
401-D1	Date of Service	9(08)	M	YYYYMMDD
AM20	**RESPONSE MESSAGE SEGMENT**			**Optional**
111-AM	Segment Identification	X(02)	M	20
504-F4	Message	X(01) – X(200)	O	Will contain the unique Internal Control Number (ICN) assigned when the claim is adjudicated in real-time. The ICN must be given to the Help Desk when requesting assistance with the claim.
AM21	**RESPONSE STATUS SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	21
112-AN	Transaction Response Status	X(01)	M	R = Rejected Claim D = Duplicate Claim
503-F3	Authorization Number	X(20)	O	
510-FA	Reject Count	9(02)	M	
511-FB	Reject Code	X(03)	M	
546-4F	Reject Field Occurrence Indicator	9(02)	O	
130-UF	Additional Message Information Count	9(02)	O	
132-UH	Additional Message Information Qualifier	X(02)	O	
526-FQ	Additional Message Information	X(01) - X(40)	O	
131-UG	Additional Message Information Continuity	X(01)	O	
549-7F	Help Desk Phone Number Qualifier	X(02)	O	03 = Processor/PBM
550-8F	Help Desk Phone Number	X(18)	O	1-800-776-6334
AM22	**RESPONSE CLAIM SEGMENT**			**Required**
111-AM	Segment Identification	X(02)	M	22
455-EM	Prescription/Service Reference Number Qualifier	X(01)	M	1 = Rx Billing
402-D2	Prescription/Service Reference Number	9(12)	M	

Section 9   <u>NCPDP 1.2 Batch Specifications</u>

9.1   <u>NCPDP 1.2 Batch Transactions Format</u>

The following tables outline the NCPDP 1.2 Batch Transactions segment and field specifications for submitting NCPDP Batch 1.2 transactions to New Jersey Medicaid.

Requirements in the Batch Transaction Standard that are specific to New Jersey DMAHS are indicated below.

Field	Field Name	Positions	Usage	NJ Specific Requirement
TRANSACTION HEADER SEGMENT				**Required**
880-K4	Text Indicator	1	M	Hex 02 (Stx)
701	Segment Identifier	2-3	M	00
880-K6	Transmission Type	4	M	T = Transaction
880-K1	Sender ID	5-28	M	7 digit Submitter number
806-5C	Batch Number	29-35	M	Unique number assigned by sender, matches trailer (must be 7 digit number)
880-K2	Creation Date	36-43	M	CCYYMMDD
880-K3	Creation Time	44-47	O	HHMM
702	File Type	48	M	P = Production, T = Test
102-A2	Version /Release Number	49-50	M	12
880-K7	Receiver ID	51-74	M	610515
880-K4	Text Indicator	75	M	Hex 03 (Etx)
DETAIL DATA RECORD				**Required**
880-K4	Text Indicator	1	M	Hex 02 (Stx)
701	Segment Identifier	2-3	M	G1
880-K5	Transaction Reference Number	4-13	M	
SEE THE NCPDP D.0 DATA RECORD AND NCPDP D.0 REVERSAL RECORD SEGMENTS FOR ORIGINAL B1, B2 REVERSAL (VOID) AND B3 ADJUSTMENT TRANSACTIONS.				
880-K4	Text Indicator	Varies	M	Hex 03 (Etx)
TRAILER RECORD				**Required**
880-K4	Text Indicator	1	M	Hex 02 (Stx)
701	Segment Identifier	2-3	M	99
806-5C	Batch Number	4-10	M	Should match Header
751	Record Count	11-20	M	File record count including header and trailer
504-F4	Message	21-55	O	Will contain the unique Internal Control Number (ICN) assigned when the claim is adjudicated in real-time. The ICN must be given to the Help Desk when requesting assistance with the claim.
880-K4	Text Indicator	56	M	Hex 03 (Etx)

Section 10 Error Response Specifications

The NCPDP standards only allow for a reject or error response at the file level. When the file fails an edit at the header or trailer record levels the entire batch file is rejected and an error response file is created and made available for the submitter to download.

The error response consists of a Transaction header section and a Trailer record. The trailer record will contain an explanation for the rejection of the file.

Field	Field Name	Positions	Usage	NJ Specific Requirement
TRANSACTION HEADER SEGMENT				**Required**
880-K4	Text Indicator	1	M	Hex 02 (Stx)
701	Segment Identifier	2-3	M	00
880-K6	Transmission Type	4	M	E = Error
880-K1	Sender ID	5-28	M	7 digit Submitter number
806-5C	Batch Number	29-35	M	Unique number assigned by sender, matches trailer
880-K2	Creation Date	36-43	M	CCYYMMDD
880-K3	Creation Time	44-47	O	HHMM
702	File Type	48	M	P = Production, T = Test
102-A2	Version /Release Number	49-50	M	12
880-K7	Receiver ID	51-74	M	610515
880-K4	Text Indicator	75	M	Hex 03 (Etx)
TRAILIER RECORD				**Required**
880-K4	Text Indicator	1	M	Hex 02 (Stx)
701	Segment Identifier	2-3	M	99
806-5C	Batch Number	4-10	M	Should match Header
751	Record Count	11-20	M	File record count including header and trailer
504-F4	Message	21-55	O	Explanation for rejection of file
880-K4	Text Indicator	56	M	Hex 03 (Etx)

10.1 Pharmacy EMC (Electronic Media Claims) Proof Reports

Pharmacy EMC Proof Reports are error reports that are mailed to the NCPDP 1.2 batch submitter to report an error(s) found for a particular transaction(s) within the NCPDP 1.2 batch file processed by the NJMMIS System. The error message, "Parsing error for segment(s)" will be reported in the response file for the transaction(s) that contained an error in the format structure for a particular transaction(s) disallowing the transaction to adjudicate. The transaction containing the error will be reported in the Record Number column of the error report.

```
REPORT ID: XC151R03                       STATE OF NEW JERSEY                       PAGE:    1
RUN DATE:  01/01/2012                  DEPARTMENT OF HUMAN SERVICES
                          DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
                                    PHARMACY EMC PROOF REPORT

FILE NAME : 8800000_0001234.dat    SUBMITTER ID : 8800000  DATE PROCESSED : 01/01/2012

    RECORD NUMBER           SEGMENT NUMBER           FIELD NAME
    ---------------         --------------          ----------
             91                   HD

RECORDS RECEIVED -      753   RECORDS ON TRAILER -      753   CLAIMS ADJUDICATED -    750
NUMBER OF FORMAT ERRORS -             1    FORMAT ERRORS FOUND ON THIS FILE
```

Transactions containing errors should be corrected and resubmitted in the next batch for processing.