CHANGE HEALTHCARE PROVIDER MANUAL

CHANGE HEALTHCARE

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CHANGE HEALTHCARE

1. INTRODUCTION TO THE CHANGE HEALTHCARE PROVIDER MANUAL (CHPM)

The Change Healthcare Provider Manual (**CHPM**), includes the policies and procedures for pharmacies, pharmacists, as well as pharmacy staff (collectively, Participating Pharmacies) who serve Participants pursuant to the Change Healthcare Participating Pharmacy Agreement (**Agreement)**. This CHPM supersedes and replaces all previous versions of the Change Healthcare pharmacy manual by whatever name. This CHPM and its contents are confidential and proprietary to Change Healthcare and are subject to the confidentiality provisions of the Agreement. This CHPM and its contents may not be reproduced, transmitted, published, or disclosed to others without Change Healthcare's prior written authorization.

The CHPM is incorporated into and is a part of your Agreement. As a Participating Pharmacy, you are responsible for monitoring and complying with all changes to the CHPM. Failure to adhere to any of the provisions and terms of the Agreement, which includes this CHPM, as well as all other applicable documents, will be viewed as a breach of the Agreement and grounds for termination.

- Information in the CHPM is current at the time of publication.
- While efforts are made to keep the information current, CHPM is subject to change without notice.
- The CHPM is not designed to cover all circumstances or issues, nor is it a replacement for sound clinical judgment.

2. DEFINITIONS

Any capitalized term used herein shall have the meaning provided in the Agreement, herein, or are derived from CMS regulations and other program documents:

3. CONTACT INFORMATION

The following will give you information on how to contact Change Healthcare when issues arise or you need assistance

A. PHARMACY HELPDESK

Change Healthcare Pharmacy Helpdesk should always be contacted first for any processing issues or research of benefit issues on behalf of a Participant.

Hours of Operation: Monday – Friday: 8:30 AM ET – 10:00 PM ET
Saturday: 9:00 AM ET – 8:00 PM ET
Sunday: 10:00 AM ET – 8:00 PM ET

Phone numbers are based on service needed

Therapy First- Branded Emdeon- 800-422-5604
Stockton- 800-577-6484
General- 800-433-4893
Alphascrip- 877-274-3244
RX.COM PBC- 877-403-1702
Ascella- 866-892-5684
USARX- 855-781-5238
TripleFin - 855-282-4888

Fax: 866.543.7085 (attention SelectRx)

E-mail: SelectRx Help Desk <SelectRx_Help_Desk@changehealthcare.com

B. PROVIDER RELATIONS

Change Healthcare Provider Relations should be contacted for any pharmacy updates to information, 835 research, check research, contract related questions, and any issues that cannot be resolved by calling the Pharmacy Helpdesk.

Hours of Operation: Monday – Friday 7:30am to 4:30pm EST.
Fax: 615-340-6160
E-mail: provider.relations@changehealthcare.com

C. BLAST COMMUNICATIONS

Change Healthcare will periodically communicate with Participating Pharmacy electronically via facsimile (i.e., fax) process or email, general announcements, updates to procedures, CHPM updates, and new plan information or Pharmacy Plan Specifications (“**Blast Communications**”).

Blast Communications are generally sent electronically via e-mail to the contracted entity (Chain, Group Purchasing Organization <GPO> or Pharmacy Services Administrative Organization <PSAO>) corporate office, and to independently owned pharmacies via either e-mail or fax transmission.

All Blast Communications will be made available upon request. To request copies of previously sent Blast Communications, please contact us at provider.relations@changehealthcare.com.

4. PROVIDER FORMS

A. ACH/EFT REQUEST FORM

Change Healthcare Provider Relations will accept ACH/EFT (electronic funds transfer) forms for **Participating Pharmacies to set up automatic payments to their identified bank accounts.

All forms (see Attachment 1) will need to be accompanied by a copy of a voided check or bank letter to validate the account. Once the completed form is received, the information will be entered into the system and be effective approximately 2 weeks from the date of receipt of fully completed and legible form(s). Forms should be e-mailed to provider.relations@changehealthcare.com or faxed to 615-340-6160.

Once a Participating Pharmacy's banking information has been entered, Change Healthcare will send a system generated e-mail, from HP-AUTOMAIL. This will be the confirmation that the Participating Pharmacy banking information has changed. Change Healthcare will send this type of e-mail any time changes are made to a Participating Pharmacy's banking information. There is nothing Participating Pharmacy needs to do if it has authorized these changes. If Participating Pharmacy receives such an email and has not requested changes through Change Healthcare directly or through Participating Pharmacy's central pay agent, Participating Pharmacy should promptly contact Provider Relations immediately at provider.relations@changehealthcare.com.

Participating Pharmacies who have entered into a central pay agreement with another entity such as a chain or PSAO/GPO ("Central Pay Pharmacies**") cannot receive EFT directly from Change Healthcare. Central Pay Pharmacies will be paid through the entity with which they have the agreement and all questions regarding payment must be directed to the respective Chain, PSAO or GPO. PSAO represents and warrants that it has authority to collect payments due under the Agreement on behalf of a Participating Pharmacy contracted with such PSAO and, for the term of the Agreement and any renewals, shall continue to possess the authority to collect such payments on behalf of such Participating Pharmacies.

B. 835 REQUESTS

Change Healthcare will provide 835 remittances upon request to any **Participating Pharmacy. To Request an 835 set up, Participating Pharmacy must have a valid e-mail address and Tax ID number to be set up within the Change Healthcare SFTP server. Once set up is completed, Change Healthcare will provide Participating Pharmacy with a username and password and instructions for connecting to the SFTP site. Requests for set up under this section along with the required information must be sent to provider.relations@changehealthcare.com.

**Participating Pharmacies who have entered into a central pay agreement with another entity such as a chain, PSAO/GPO, or 835 processor will not receive an 835 directly from Change Healthcare. 835 remittances for Central Pay Pharmacies will be sent directly to the applicable chains, PSAO/GPO, or 835 processors on behalf of those Central Pay Pharmacies such entities service.

A request to update a pharmacy relationship should be sent to provider.relations@changehealthcare.com.

C. MAC APPEAL PROCESS

To comply with applicable state laws, Change Healthcare has implemented an appeal process to allow Participating Pharmacies to dispute any MAC pricing for a Covered Prescription Service. The process includes a review and investigation to resolve MAC disputes. The information listed below must be sent within 30 days of the date of service. All appeals to a MAC price must be sent to provider.relations@changehealthcare.com. MAC appeals will be resolved within 5 business days from the receipt of all required information. The following information must be sent for a MAC appeal to be processed:

- Pharmacy NCPDP or NPI
- Date of Service
- Rx number
- The amount of the Claim in question
- An invoice showing the price paid for the drug in question

If the drug in question is not a MAC priced drug the Claim will be returned with the response "NOT A MAC DRUG".

Any drug considered for adjustment will be sent back with the new adjusted price and date of adjustment.

Participating Pharmacies that contract through a PSAO or chain affiliation must send their MAC appeal through the contracting entity for review. Change Healthcare will review the Claim with the contracting entity and respond directly to such contracting entity.

To the extent that Participating Pharmacy is in a state requiring a time period shorter than those set forth above to submit or resolve a MAC appeal than noted above, Change Healthcare will follow the state requirement where such Participating Pharmacy is located.

5. CREDENTIALING, PROCESSING and PAYMENT

A. CREDENTIALING

Change Healthcare has the right to determine whether Participating Pharmacy meets and maintains the appropriate credentialing standards to participate as a Participating Pharmacy in Change Healthcare network(s). Participating Pharmacy agrees to provide Change Healthcare with documentation and other Pharmacy Information which may be needed in connection with credentialing and re-credentialing as required by Change Healthcare. Participating Pharmacy shall ensure that its Pharmacy Information (including a complete list of Participating Pharmacy locations, including addresses, phone numbers, hours of operation, related services, NCPDP number, NPI number, License numbers, etc.) is accurate and up-to-date with Change Healthcare and NCPDP, and shall promptly provide written updates thereto.

Change Healthcare may require Participating Pharmacy, at Change Healthcare's sole discretion, to provide hard copy documentation of licenses, insurance verification, and any other verification documentation for purposes of the course of doing pharmacy business. Such documentation must be provided within 3 business days of the request. Participating Pharmacy acknowledges and agrees that its information may be searched through pubic databases and information sources to verify its Pharmacy Information and credentialing/re-credentialing information, including various

federal and state databases, data available through disciplinary and licensing boards and court systems, through insurance companies, regulator exclusion lists, etc. Participating Pharmacy consents to the inspection and release of all Pharmacy Information by Change Healthcare and authorizes anyone in possession of Pharmacy Information and/or other information or documentation required by Change Healthcare for evaluation of Participating Pharmacy's credentialing and re-credentialing, including qualifications and competence, to release such information to Change Healthcare for use in its credentialing and re-credentialing activities. Change Healthcare's right to conduct this primary source verification does not limit or reduce Participating Pharmacy's obligations hereunder to timely report and update such information as set forth herein.

Change Healthcare requires each Participating Pharmacy to update and maintain a pharmacy profile with NCPDP up to and including all licensing, demographics and service information. Change Healthcare may rely on the information contained in the NCPDP database for purposes of credentialing, re-credentialing, directories, and payments. Participating Pharmacy shall ensure that all data in the NCPDP databases regarding Participating Pharmacy is accurate and complete (all fields completed), and must notify and submit all changes to NCPDP immediately, in order to ensure timely processing. Failure to ensure accurate and complete information regarding Participating Pharmacy in the NCPDP databases may result in Claims be reimbursed incorrectly.

Change Healthcare may deny, suspend or terminate Participating Pharmacy from participation in any or all networks for failure to complete, maintain or provide accurate information with NCPDP or for not maintaining the proper credentialing in the course of doing business as a Participating Pharmacy. In connection with re-credentialing initiatives, which may include the same requirements as initial credentialing, Change Healthcare may also consider (among other things) any Participant complaints, quality improvement review studies, utilization management review studies, pharmacy audits, and customer satisfaction surveys.

Change Healthcare retains the right to determine, in its sole discretion, whether a Participating Pharmacy meets/maintains the appropriate credentialing, as well as maintains the standards to meet the needs of Change Healthcare or its Plan Sponsors and Participants.

Participating Pharmacy and each pharmacy location covered under the Agreement must abide by all Laws, and at all times must remain in good standing with all Laws, Licenses, and permits as required in the course of doing pharmacy business. Failure to maintain the proper Licenses, permits and insurance may result in immediate termination as a Change Healthcare Participating Pharmacy.
Participating Pharmacy must notify Change Healthcare in writing if:

- Participating Pharmacy's License or permit is in jeopardy of being suspended or revoked.
- Closure or change of licensure
- Any disciplinary action is taken against Participating Pharmacy or any of its personnel, including but not limited to, action taken by a Board of Pharmacy, OIG, GSA, law enforcement or other regulatory body.

B. CLAIMS PROCESSING

Change Healthcare requires the submission of all Claims according to the NCPDP standards, in order to submit such Claims for proper payment and application of Copayments, COB and other related pharmacy services. This requirement applies whether or not any additional amounts are owed to Participating Pharmacy over the amount paid by the Participant. Participating Pharmacy shall provide and maintain at its expense the equipment, software, and communications network transmission capabilities necessary to submit Claims and to receive POS System processing messages, including DUR messages and Formulary information, from Change Healthcare or its designee. The telecommunications interface equipment and all other systems used by

Participating Pharmacy shall be the responsibility of Participating Pharmacy and shall meet the minimum standards set by Change Healthcare from time to time, and as otherwise required by applicable Law, including HIPAA. Participating Pharmacy is responsible for any claims processing fees through claims switch processors.

Participating Pharmacies should use best efforts to submit complete and accurate Claims in the POS System or such other method as determined by Change Healthcare.

Reversals: Claims reversal windows may vary by Plan Sponsor however, Claims must be reversed within a maximum of 14 days, to remain within a billing cycle to assure prescriptions with inaccurate information or those not dispensed to Participants are credited in a timely fashion within the same billing cycle. All Prescriptions not received by a Participant must be reversed within 14 days from original submission. Claims not reversed within 14 days may be subject to audit and may be collected through the pharmacy audit process.

Timely Submission: All Claims should be submitted within 30 days of the date of service to ensure processing within the online claim submission window. Participating Pharmacies that need to process Claim(s) outside the online submission window time will be required to submit a UCF and an explanation for the late submission.

- Submission of the UCF is not a guarantee that the Claim(s) will be paid.
- Payment is determined on a case-per-case basis upon review of explanation of late submission and Client or Plan Sponsor approvals.

Resubmissions: In the event a Claim or Transaction rejects at the point-of-sale, reasonable attempts must be made to retransmit the Claim. In the event the retransmission fails, Participating Pharmacy may call the applicable Help Desk contact number for assistance or alternative arrangements to submit the Claim.

Required Claim Information: For each Claim for a Covered Prescription Service filled and dispensed by a Participating Pharmacy for a Participant, Participating Pharmacy is required to transmit information to Change Healthcare consistent with the following:

- NCPDP D.0 format billing transaction or an updated format at the discretion of Change Healthcare.

- Any additional information necessary to comply with the applicable payer sheet, which details all of the requirements for submitting a Claim using the NCPDP D.0 format.

- Some coupon/voucher programs require primary insurance to be billed first and submission of secondary coverage to Change Healthcare for copay assistance and usage of the coupon.

- Participating Pharmacies should verify with Participants to identify if they have primary or other secondary insurance coverage, and should refer to the online Transaction response, if any, to facilitate COB processing. Amounts paid by or due to Participating Pharmacy on a COB Claim may be reduced by the amounts paid or due by other insurers or payers.

- Fields marked as situational require data as needed under the defined situation in the comment section.

- Claims submitted that are missing data in mandatory or required fields, or where data is required under situational conditions, will be rejected and will not be considered a paid Claim.

- The NCPDP D.0 format can handle the exact metric decimal quantity correctly, and Participating Pharmacy may not adjust the quantity by rounding prior to submitting the Claim.

- Participating Pharmacies filling for pharmaceutical manufacturer's coupon programs that require primary insurance to be billed first may not bill a 100% copay discount card program as primary insurance for a Participant. All Participating Pharmacies shall review each coupon/voucher to determine processing guidelines and whether or not discount cards program can be billed as a primary. Participating Pharmacies in violation of this requirement may be subject to audit, recovery, and other administrative actions up to and including termination from Change Healthcare networks.

- Participating Pharmacy is responsible for entering the correct days' supply on all Claim submissions. The days' supply must accurately reflect the documented directions and quantity dispensed.

- Participating Pharmacies must use the proper Dispense As Written (**DAW**) codes to ensure proper cost sharing for the Participant.

DAW Codes/Product Selection: Change Healthcare allows submission of all DAW codes. NCPDP DAW codes range from 0-9 depending on the reason product Brand Name Drug was selected for dispensing.

DAW 0 — No Product Selection Indicated
This is the field default value which is appropriately used for Prescriptions for single source brand, co-branded/ co- licensed or generic Drug Products. For a multi-source Brand Name Drug with available Generic Drug(s), DAW 0 is not appropriate and may result in a reject.

DAW 1 — Substitution Not Allowed by Prescriber
This value is used when the Prescriber indicates, in a manner specified by prevailing Law, that the product is medically necessary to be dispensed as written. DAW 1 is based on Prescriber instruction and not Drug Product classification. Participating Pharmacy must document "DAW 1" on the original Prescription specifying the Prescriber's request to dispense the Brand Name Drug

DAW 2 — Substitution Allowed-Patient Requested Product Dispensed
This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted and the Participant requests the Brand Name Drug. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

DAW 3 — Substitution Allowed-Pharmacist Selected Product Dispensed
This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted and the Participating Pharmacy determines that the Brand Name Drug should be dispensed. This can occur when the Prescriber writes the Prescription using either the Brand Name Drug or Generic Drug and the Drug Product is available from multiple sources.

DAW 4 — Substitution Allowed-Generic Drug Not in Stock
This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that Generic Drug substitution is permitted and the Brand Name Drug is dispensed since a currently marketed Generic Drug is not stocked in the pharmacy. This situation exists due to the buying habits of the Participating Pharmacy, not because of the unavailability of the Generic Drug in the marketplace.

DAW 5 — Substitution Allowed-Brand Drug Dispensed as a Generic

This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that Generic Drug substitution is permitted and the Participating Pharmacy is utilizing the Brand Name Drug as the Generic Drug entity.

DAW 6 — Override
This value is used by various claim processors in very specific instances as defined by the claim processor and/or its clients.

DAW 7 — Substitution Not Allowed-Brand Drug Mandated by Law
This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that Generic Drug substitution is permitted but prevailing Law or regulation prohibits the substitution of a Brand Name Drug even though Generic Drug versions of the Drug Product may be available in the market place.

DAW 8 — Substitution Allowed-Generic Drug Not Available in Marketplace
This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that Generic Drug substitution is permitted and the Brand Name Drug is dispensed since the Generic Drug is not currently manufactured, distributed, or is temporarily unavailable.

DAW 9 — Substitution Allowed by Prescriber but Plan Requests Brand-Patient's Plan Requested Brand Product To Be Dispensed
This value is used when the Prescriber has indicated, in a manner specified by prevailing Law, that Generic Drug substitution is permitted, but the Plan Sponsor's Formulary requests the Brand Name Drug. This situation can occur when the Prescriber writes the Prescription using either the Brand Name Drug or Generic Drug and the Drug Product is available from multiple sources.

Most Participants have a choice between a Brand Name Drug and Generic Drugs. However, in some programs the Participant will pay the difference between the cost of the Brand Name Drug and the available Generic Drug. Accordingly, correct DAW submissions indicate if a penalty is applicable, and must be accurately submitted by the Participating Pharmacy.

Compound Drugs: Participating Pharmacies are prohibited from submitting Claims for Compound Drug without a valid Prescription. Evidence that Participating Pharmacy is manufacturing Compound Drugs without a valid Prescription will be cause for reversal and/or nonpayment of applicable Claim(s), suspension, and/or termination. Covered Prescription Services which are Compound Drugs must be submitted to Change Healthcare using the NDC of the most expensive legend drug. Compound Drugs must contain at least one ingredient that is a legend drug, the compound indicator field must indicate that the Claim is for a Compound Drug, and the appropriate fields in the Compound Drug segment must be completed. Covered Compound Drugs are paid in accordance with a Participating Pharmacy's submitted Claim information and subject to any contractual, Plan Sponsor, and network benefit design. If an excluded agent is included in the Compound Drug, the Claim will reject for "invalid compound".

Specialty Drug Dispensing: Participating Pharmacy shall submit Claims for Specialty Drug dispensing in accordance with the Agreement or as otherwise instructed by CHC. Participating Pharmacy shall at all times exhibit clinical expertise in specialty therapies associated with Participants' chronic conditions and disease specific care coordination related to the Specialty Drugs dispensed by Participating Pharmacy to help promote quality, safety, and clinical effectiveness for such therapeutic categories.

When dispensing Specialty Drugs to Participants, Participating Pharmacy shall provide to Participants all ancillary supplies appropriate for the administration of the medication dispensed at no additional charge (i.e., disposal containers, needles, syringes, alcohol wipes, etc.).

Participating Pharmacy shall provide to Participants, CHC, and Plans toll-free telephone access to a currently licensed pharmacist and nurse twenty-four (24) hours a day, seven (7) days a week. In addition, Participating Pharmacy shall provide to CHC and its Plans toll-free telephone access to customer service representatives during the same hours offered to other users of Participating Pharmacy, which must be at least during normal business hours of Participating Pharmacy.

Participating Pharmacy shall provide pharmaceutical care management as required by CHC, applicable pharmaceutical manufacturers, and/or Plans, which shall at a minimum include, but not be limited to: provision of educational information and medication administration training for Participants; care coordination to assist Participants with refills and claims inquiries; registered nurses and pharmacists on staff to promote adherence and educate Participants on potential side effects of medications and address other pertinent Participant clinical inquiries; live, one-on-one contact, either in person or by telephone, with each Participant at each refill; documentation of the therapy management contact and patient profiling, focusing on the appropriateness of the specialty medication therapy and care, prevention of drug-drug interactions, and non-adherence; follow up with prior authorizations and proactive renewal services to help ensure continuous uninterrupted therapy without the use of auto-refills; intervention programs to include communications with Participants' physician(s); monitoring and maintenance programs; compliance programs; educational information to Participants on a new therapy and Participants currently on a therapy; disease management programs; patient assistance program information to Participants who have exhausted coverage; and intervention programs, as applicable, unless otherwise prohibited by CHC.

If Participating Pharmacy or CHC identifies that Participating Pharmacy has not complied with any requirements applicable to the dispensing of Specialty Drugs to Participants, Pharmacy shall submit a corrective action plan to CHC within 14 days of receipt of notification from CHC to correct the deficiency. Upon CHC's approval of the corrective action plan, Participating Pharmacy shall immediately implement the plan. CHC, in its discretion, may audit Participating Pharmacy's compliance with the corrective action plan within a reasonable time as determined by CHC. Participating Pharmacy understands and agrees that its compliance with each of the requirements in the Agreement is a material condition of Participating Pharmacy's approval by CHC for Specialty Drug dispensing hereunder. In accordance with the Agreement, CHC may terminate the Agreement for Participating Pharmacy's failure to meet or exceed any of these requirements.

Fills and Refills. Participating Pharmacy shall fill and refill Covered Prescription Services only when there is a valid prescription order and then in accordance with Law, Pharmacy Plan Specifications, and the Agreement. Participating Pharmacy shall not process a fill or refill for a Prescription for a Participant unless and until such fill or refill has been requested or authorized by the Participant. Participating Pharmacy shall maintain documentation of such request/authorization by the Participant. Without limiting the generality of the foregoing, this requirement shall apply regardless of whether the Prescription was received by Participating Pharmacy from the Participant or by a transfer of the Prescription from another provider – both the transferring pharmacy and the receiving pharmacy are responsible for ensuring such authorizations are obtained and for maintaining such documentation. For avoidance of doubt, failure to obtain and maintain such documentation shall be grounds for nonpayment of the Claim(s), suspension, and/or termination.

Taxes: If any taxes, assessments, and/or similar fees ("taxes") are imposed on Participating Pharmacy by a governmental authority based on Participating Pharmacy's provision of Covered Prescription Services to Participants, Participating Pharmacy shall submit with each Claim for payment, and in compliance with the transactions standards required by Law, the amount of such taxes, which Participating Pharmacy is required by Law to pass on to Plan Sponsors. In order to be reimbursed for the payment of tax, Participating Pharmacy must transmit the applicable tax amount allowed by Law through the POS System in the correct amount and in the appropriate field

on the Claim submission. In no event does this give Participating Pharmacy any additional or different rights than those allowed by Law or permit Participating Pharmacy to charge or collect such taxes from Participants. Participating Pharmacy shall remain solely responsible for payment to the appropriate governmental authorities of all taxes related to the Covered Prescription Services provided by Participating Pharmacy under this Agreement. In no event shall Change Healthcare be liable for any such taxes or the determination of the existence or amount of such taxes.

Manufacturer Submissions. Participating Pharmacy acknowledges and agrees that Change Healthcare has the right to submit all Claims for Covered Prescription Services to pharmaceutical companies and/or rebate intermediaries or aggregators in connection with rebate and any similar programs. Participating Pharmacy shall not submit any Claims for Covered Prescription Services to any pharmaceutical company or others for the purpose of receiving any rebate or discount (excluding purchase discounts).

Non-Discrimination. Participating Pharmacy will not differentiate or discriminate in providing Covered Prescription Services because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, any protected class under applicable Law, and/or participation in publicly financed programs of health care services. Participating Pharmacy will provide Covered Prescription Services in the same location, in the same manner, in accordance with the same standards, and within the same time and availability, regardless of Plan Sponsor.

Change in AWP. If a change in AWP calculation methodology occurs or if the AWP is substituted by any other pricing metric in the market place (a "**Change Event**"), upon notice of an anticipated Change Event by one party to the other party the parties will negotiate in good faith to reach a new agreement on the applicable reimbursement rate. Any such new reimbursement rates will be effective as of the day of the Change Event or as otherwise agreed. Such new reimbursement rates will be comparable to the rates used on the day immediately preceding the Change Event so the parties' economic position will remain consistent with the terms and conditions of the Agreement, all of which is intended to maintain substantially price neutral economics.

C. PAYER SHEETS (See Attachment 2)

D. PAYMENT

Change Healthcare makes pharmacy payments twice a month: one payment cycle covers Claims from the 1st through the 15th and the second payment cycle covers Claims from the 16th through the end of the month. Payments to Participating Pharmacies are subject to Plan Sponsor funds being received by Change Healthcare and payments are typically made 30-45 days after the end of the date of the payment cycle.

- Participating Pharmacies have the option to enroll in ERA 835 electronic remittance advice and ACH/EFT Electronic Funds transfer as specified in Section 3.A. of this CHPM.

- Participating Pharmacy should always ensure their NCPDP relationship information is up to date and accurate to ensure proper handling of their funds.

- All Participating Pharmacies are required to fill out an ACH/EFT form and submit to Change Healthcare with a voided check or bank letter verifying the information and the use of a PIN number is required for the form to be considered complete.

Notwithstanding anything to the contrary in this CHPM or the Agreement, all Participating Pharmacy Claims are subject to a service fee assessed on each Claim as specified in the Agreement.

Except as expressly permitted herein or in writing by Change Healthcare, Participating Pharmacy is required to submit all Claims via the POS System along with the applicable Usual & Customary (U&C) price, and to collect the applicable Copayment.

Objection to Payment, Under Payment, Deductions, and Charges. Participating Pharmacy shall notify Change Healthcare in writing of any alleged error, miscalculation, discrepancy, or basis for challenging the correctness or accuracy of any remittances, Claims (whether paid, denied, rejected, reversed, or otherwise), deductions, recoupments, offsets, charges, fees, and/or tax amounts within 30 days after any remittance advice, invoice, notice, or other report is sent to or made available to Participating Pharmacy, except as otherwise required by Law. Written objection must be timely submitted to Change Healthcare, along with sufficient documentation to support Participating Pharmacy's challenge. If Participating Pharmacy fails to notify Change Healthcare of its objection as required herein, Participating Pharmacy will be deemed to have confirmed the accuracy of the Claims, deductions, recoupments, offsets, charges, fees, and tax amounts as set forth in the remittance advice, invoice, notice, or other report for that cycle. Thus, all Claims, deductions, recoupments, offsets, charges, fees, and tax amounts will be final as to Participating Pharmacy on the 30th day following the date the remittance advice, invoice, notice, or other report is sent or made available to Participating Pharmacy, and will not be subject to challenge thereafter by Participating Pharmacy. This section does not apply with respect to any overpayments made to Participating Pharmacy.

Collection of Participant Copayment. Plan Sponsors determine the amounts which Participating Pharmacy is required to collect from a Participant for Covered Prescription Services at the point of sale, which will vary by Plan Sponsor and/or Program. Unless otherwise directed by Change Healthcare in writing, Participating Pharmacy shall collect from Participants the amounts as indicated in the POS System. If Change Healthcare determines that Participating Pharmacy has charged or collected from a Participant an amount in excess of the amount specified by the POS System: (i) Participating Pharmacy shall promptly reimburse the Participant for the excess amount upon Change Healthcare's request; or (ii) Change Healthcare may offset such amounts from amounts otherwise owed to Participating Pharmacy.

Claims Payments. Subject to the terms of the Agreement and after deducting the applicable amounts Participating Pharmacy is required to collect from Participants, Participating Pharmacy's compensation shall be the lesser of: (i) the ingredient cost and dispensing fee submitted by Participating Provider; (ii) applicable discount rates and Dispensing Fees specified within the rate schedule; (iii) the Participating Pharmacy's U&C; and (iv) if applicable, lesser of the amount set forth in the applicable government fee schedule or government allowed amount. Participating Pharmacy accepts such amount as payment in full for Covered Prescription Services rendered to Participants in accordance with this Agreement. Participating Pharmacy's failure to comply with the terms and conditions of this Agreement may result in nonpayment to Participating Pharmacy.

Amounts Due from Participating Provider and Offset Rights. Change Healthcare shall have the right to invoice or deduct amounts due by Participating Pharmacy to Change Healthcare, Plan Sponsor, and/or Participants hereunder, including service fees, overpayments, penalties, and/or other fees, charges, or payments of any kind provided for under this Agreement from amounts otherwise payable to Participating Pharmacy hereunder. In the event of an invoice sent by Change Healthcare, Participating Pharmacy shall pay such invoice amounts within 30 days of receipt of the invoice or as otherwise specified in this Agreement. In the event of a deduction, Change Healthcare may offset from amounts due Participating Pharmacy all amounts due hereunder. Participating Pharmacy agrees not to attempt to affect an accord or satisfaction through a payment instrument or accompanying written communication, and Participating Pharmacy further agrees not to conditionally or restrictedly endorse any payment instrument. In either case, Change Healthcare shall not be bound by any such attempt or endorsement. For avoidance of doubt, Participating Pharmacy acknowledges and agrees that with respect to certain Claims (e.g., discount card),

Change Healthcare shall have the right to invoice or deduct/offset from amounts otherwise payable to Participating Pharmacy under this Agreement amounts paid by Participants in excess of the amounts due hereunder. Failure of Participating Pharmacy to pay amounts due under this Agreement is grounds for suspension and/or termination.

Payment Reversals, Withholds, Suspensions. Change Healthcare may reverse, withhold, and/or suspend payment due hereunder: (i) as directed by Medicare, Medicaid, other governmental entity, or Plan Sponsor; (ii) in cases where there is reasonable suspicion of fraud, waste, abuse, or misrepresentation and/or suspicious Claims activity; (iii) when a Prescriber denies having written a Prescription in connection with a Claim submitted by Participating Pharmacy; and/or (iv) Participant reports that he/she did not authorize the fill or refill by Participating Pharmacy. In such cases, the Claim amounts shall not become due and owing hereunder until: (a) such amounts are allowed to be paid by Medicare, Medicaid, other governmental entity, or Plan Sponsor; (b) the suspicion of fraud, waste, abuse, or misrepresentation and/or suspicious Claims activity has been fully resolved with the determination of no fraud, waste, abuse, or misrepresentation by Change Healthcare and or a tribunal of competent jurisdiction;(iii) the Prescriber denial and/or Participant denial/report has been fully resolved to Change Healthcare's satisfaction or by a tribunal of competent jurisdiction. This section will survive termination of this Agreement.

Penalties. To the extent Change Healthcare and/or Plan Sponsors incur penalties or other charges that result from Participating Pharmacy's actions, inactions, or other failure to comply with this Agreement and/or applicable Laws, Participating Pharmacy shall immediately owe and pay any such penalties and other charges imposed upon Change Healthcare and/or Plan Sponsors upon notice from Change Healthcare. This section will survive termination of this Agreement.

Consumer Discount Card Programs/Unfunded Business. As applicable and to the extent that Participating Pharmacy is a participant in a consumer discount card/unfunded business network, Change Healthcare will communicate to Participating Pharmacy via the POS System the discounted amount to collect from the Participant ("**Participant Amount**"). The Participant Amount may be more than the contracted rate owing to Participating Pharmacy and may vary from the AWP discount, MAC, or dispensing fee owed to Participating Pharmacy. Participating Pharmacy agrees to collect from the Participant at the point of sale the full Participant Amount indicated by the POS System. Change Healthcare may withhold from other payments due to Participating Pharmacy under the Agreement or may invoice Participating Pharmacy for the difference in the Participating Pharmacy contracted rate hereunder and the Participant Amount. The Participant Amount will not exceed Participating Pharmacy's U&C. In no event will Participating Pharmacy charge a Participant more than the lower of the Participating Pharmacy's U&C or the Participant Amount. In no event may Participating Pharmacy reverse and reprocess any Change Healthcare or Plan Sponsor cash discount card Claim payable by a Participant, outside of the applicable cash discount card program, except as the specific request of the Participant.

6. NETWORK PROVIDER PARTICIPATION

A. INDEPENDENT PHARMACY

A Participating Pharmacy which is solely owned and operating on its own accord as a Retail Pharmacy with proper licensing and credentialing may contract directly with Change Healthcare as an independent Retail Pharmacy. The independent Retail Pharmacy is responsible for the following:

- Providing proper licensing, insurance, and documentation when asked by Change Healthcare to credential the pharmacy to participate in the Change Healthcare networks.
- Updating and maintaining the NCPDP Data Q online profile through NCPDP with the most current information.

- Receive payment directly through Change Healthcare or make the necessary arrangements to contract with a third-party reconciler.

B. PSAO

Pharmacies and other dispensers may delegate contracting responsibility with Change Healthcare to a PSAO. A PSAO may contract with Change Healthcare directly for pharmacies who have a contract with the PSAO. Participating Pharmacies may only be affiliated with one (1) PSAO for contracting purposes at any given time. The PSAO is responsible for the action of their contracted pharmacies and in providing the following to Change Healthcare when requested:

- A list of all pharmacies for which the PSAO is authorized to enter into the Agreement on behalf of, and any additions, deletions, or other changes to such list.
- Credentialing information for each pharmacy under the PSAO contract.
- PSAO's under central pay arrangements are responsible for ensuring payment to each contracted pharmacy.
- Ensuring their contracted pharmacies are adhering to the Agreement in place between the PSAO and Change Healthcare, and if not to ensure they become compliant in accordance with the Agreement.
- MAC appeals as specified in Section 3.C. above.
- Ensuring the information in NCPDP Data Q is being maintained and is accurate at all times for each contracted pharmacy.

In the event a Participating Pharmacy notifies Change Healthcare directly that a PSAO is no longer authorized to bind such Participating Pharmacy or that the Participating Pharmacy has contracted with a different PSAO, Change Healthcare may rely on such information and update its records with, and operate according to, such information.

By entering into the Agreement, PSAO is entering into the Agreement on its own behalf and on behalf of the each of its Participating Pharmacies. PSAO acknowledges and agrees that all references to "Participating Pharmacy" in the Agreement shall refer to and mean both PSAO and PSAO contracted Participating Pharmacies except that provisions related to the actual provision of pharmacy services to Participants and the licensure required thereunder shall not apply to PSAO. PSAO represents and warrants that it has authority to enter into the Agreement on its own behalf and on behalf of each of its contracted Participating Pharmacies and during the term of the Agreement including all renewals, PSAO shall continue to possess the authority to individually bind each contracted Participating Pharmacy to the terms and conditions of the Agreement, including all rate schedules, addendums, and amendments. PSAO shall provide to Change Healthcare evidence of such authority within 5 business days of Change Healthcare's request. PSAO contracted Participating Pharmacies shall be deemed to have accepted all terms and conditions of the Agreement. PSAO shall develop, implement, and maintain efficient and accurate procedures for notifying PSAO contracted Participating Pharmacies of their obligations under the Agreement, including any amendments or addenda thereto.

Without limiting any other provision of the Agreement, amounts owed by PSAO contracted Participating Pharmacy may be recouped: (a) directly from the Participating Pharmacy; (b) from PSAO under which Participating Pharmacy is then contracted regardless of whether or not the recoupments relate to Transactions that occurred while the Participating Pharmacy was contracted with such PSAO; and/or (c) from PSAO under which the Transactions related to such recoupments were originally processed regardless of whether or not the Participating Pharmacy is still contracted with such PSAO.

Change Healthcare's rights and remedies apply at both the PSAO and Participating Pharmacy level. Without limiting the generality of the foregoing, termination or suspension of a PSAO

contracted Participating Pharmacy shall not constitute termination or suspension of this Agreement with respect to PSAO unless otherwise specified by Change Healthcare.

PSAO and PSAO contracted Participating Pharmacies shall indemnify Change Healthcare, Plan Sponsors, and their respective members, managers, shareholders, officers, directors, employees, and agents, and their successors, representatives, and assigns thereof, and hold them harmless for, from, and against, any and all liability, loss, damage, settlement, claim, injury, demand, judgment, and expense, including attorneys' fees, arising directly or indirectly from (a) failure of PSAO and PSAO contracted Participating Pharmacies to act in accordance with their agreements with one another; and (b) any dispute between PSAO and a PSAO contracted Participating Pharmacy.

C. CHAIN

A chain pharmacy may contact Change Healthcare directly for all pharmacies associated with a particular Chain Code. A chain is responsible for the actions of all pharmacies under their association and for providing Change Healthcare with the following upon request:

- Credentialing information for each individual pharmacy location.
- Ensuring payment is made for all Claims under the association.
- Ensuring that all pharmacy locations are abiding by the terms and conditions of the Agreement between the chain and Change Healthcare; and if not, to ensure compliance under the Agreement.
- Ensuring that pharmacy location information is updated and maintained in NCPDP Data Q.

7. FWA/AUDIT

A. Fraud Prevention Program

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000.
Change Healthcare steadfastly believes that the key to prevention, detection and reporting of Fraud, Waste or Abuse (FWA) is the recognition of conditions that allow for the exploitation of pharmacy claims adjudication. The primary objective of the Change Healthcare pharmacy services audit program is to identify these potential FWA exploitations, billing errors and provide comprehensive detection, retrospective and prospective Claims analysis and preventative best practice network management recommendations for continuous quality improvement of the total prescription filling process. The auditing goal is to facilitate a more economic, effective, and

efficient network of credentialed pharmacies. Change Healthcare and its authorized agent are committed to ensuring that pharmacies are conducting their business in ethical and legal manner to safeguard the integrity of health care programs and the health and welfare of people served by them.

Participating Pharmacies are required to report any suspected or potential FWA events or activities to Change Healthcare. Change Healthcare will investigate any potential violation as reported. Participating Pharmacy is required to cooperate with these investigations.

The following is a list of potential types of FWA that could happen with a Participating Pharmacy that may result in audits, sanctions or possible termination of participation in Change Healthcare networks:

- Billing for a Brand Name Drug and dispensing a Generic Drug
- Billing for an NDC other than what was dispensed
- Overbilling of the quantity prescribed
- Billing multiple payers for the same Prescription
- Inappropriate billing of Compound Drugs
- Submitting a dummy DEA/NPI or Invalid DEA/NPI number to obtain a paid response
- Billing for a Brand Name Drug with Dispense as Written per the Prescriber (DAW 1) when a Prescriber has not specified “Do Not Substitute” on the Prescription or other inappropriate use of DAW codes
- Billing for larger pack sizes of Drug Products supplied in unbreakable packages when one smaller pack size will meet the directions of the Prescriber and remain within the Plan Sponsor’s maximum days’ supply
- Billing for more fills or refills than were authorized
- Billing for invalid Prescriptions due to lack of a legal Prescriber, forgery, or false or fictitious documents
- Dilution of Drug Product provided to Participant
- Acquisitions of Prescription Drug Products on black market and black market sales
- Collusion with Prescriber, wholesaler or others and kickback schemes
- Pill shorting to Participants: Dispensing less than quantity billed.
- Selling the same Drug Product twice: Recycling pills.
- Inappropriate, inaccurate or incomplete record-keeping practices related to billed Prescriptions
- Phantom Claim billing: Claims for Covered Prescription Services not provided
- Dispensing expired or adulterated Drug Products
- Forging or altering Prescriptions
- Refilling Prescriptions erroneously

B. Audit Program

The Change Healthcare pharmacy audit program functions as an investigative tool that utilizes the experience and knowledge of regulations, guidelines, prescription dispensing, and pharmacy claims processing to identify filling and billing errors as well as a quality assurance review to provide feedback for improvement of the total pharmacy dispensing process. The audit program is based upon proper and appropriate Claim adjudication and management, as well as reclaims collections from providers. Additionally, the program validates compliance with regulatory and operational industry recognized policies and standards and continuously improves the quality and management of the pharmacy Claims data.

The auditing goal is to foster a more economic, effective, and efficient network of Participating Pharmacies. Change Healthcare is committed to achieving results in protecting the integrity of health care programs and the health and welfare of people served by them.

Change Healthcare or its authorized agent will perform comprehensive Claims data analysis, audits, evaluations, and investigations of Participating Pharmacies regarding the Claims submitted and processed.

Ongoing Education

- Change Healthcare may provide additional information to Participating Pharmacy through a Blast Communication, mail, or email. This information may be used by Participating Pharmacy to enhance billing practices, reduce billing errors, and prepare for Change Healthcare audits.

ACCESS TO RECORDS

- During the Participating Pharmacy's regular business hours, and upon reasonable notice, Participating Pharmacy must provide access to Change Healthcare or its duly authorized agents, to the books, Records (as defined in the Agreement), wholesaler invoices, Prescription orders, signature logs/delivery logs, licensing and proof of insurance, and other information requested by Change Healthcare or its designee.
- Typical on-site and desk-top audits generally include Prescriptions dispensed within the previous 24 months. Change Healthcare reserves the right to audit Claims up to 6 years from the date of service and for all government programs, up to 10 years from the date of service or as specified by applicable Law.
- In the event Participating Pharmacy is unable to accommodate an on-site audit on the scheduled date and alternative arrangements were not agreed upon by Change Healthcare or if a Participating Pharmacy is uncooperative during such audit or non-compliant with this Agreement, Change Healthcare reserves the right to seek full recovery of any Claims.
- At no time during the audit is the Participating Pharmacy allowed to photograph or record interactions with Change Healthcare auditor (or agent) without the express written consent of Change Healthcare. Violation of this activity may result in termination.
- Participating Pharmacy may not charge Change Healthcare for any expenses with regards to personal time and records.

AUDIT TYPES:

<u>Concurrent daily Claims review:</u>

Change Healthcare monitors daily Claims to identify potential errors. Our process is designed to educate Participating Pharmacies and helps to avoid retroactive recoveries that would normally happen during a pharmacy onsite and desktop audit. The concurrent daily Claims review complements the onsite and desktop audit process.

When a Claim is reviewed, Change Healthcare (or its designated agent) will contact the Participating Pharmacy via email, phone or fax to inquire about the Claim. If it is determined that the Claim was adjudicated incorrectly, Change Healthcare will ask the Participating Pharmacy to reverse and correctly adjudicate the Claim. If other discrepancies were found, those discrepancies would be addressed during an audit.

Participating Pharmacy shall respond to request of information within 3 business days. Failure to respond may result in full or partial recovery of the amount paid and may result in escalation to another type of audit.

On-Site Audits:

An on-site audit is a pharmacy audit conducted by an auditor in person at a Participating Pharmacy or individual pharmacy location, as applicable. During each On-Site Audit, Change Healthcare or its authorized agent will audit Prescriptions and associated refills, credentials/validates proper licenses, reviews practices to regulatory requirements, and reviews a sample of the signatures in the Participating Pharmacy's patient signature log.

An auditing package is sent to Participating Pharmacy via traceable courier with instructions, a worksheet, and a request for copies and supporting documentation. Once the package is delivered, Change Healthcare or its authorized agent auditor contacts Participating Pharmacy by phone to review the requested audit response information, answer any questions, and confirm the appointment for the on-site audit. Thereafter, the Participating Pharmacy must compile copies and or images of the requested Prescriptions and segregates them for pick-up by the auditor during the on-site visit. These Prescriptions will be reviewed for accuracy and compliance at Change Healthcare or its authorized agent office.
Once at the Participating Pharmacy location, the auditor will retrieve the prepared package of copies of Prescriptions and shall conduct an audit compliance and credentialing worksheet collecting information regarding the following:

- Validate all pharmacists, technician, DEA, and State licenses
- Review conditions of the pharmacy
- Observe customer interactions
- Validate HIPAA & OBRA compliance
- Confirm existence of a return to stock procedure
- Refrigerator temperature verification
- Medication error records maintenance review
- Verify Compliance with:
    - Prospective DUR process
    - Posted "Medicare Prescription Drug Coverage and Your Rights"
    - FW&A training
    - Regular review of OIG & GSA pharmacist exclusion list
    - Conflict of interest statement and a code of conduct
    - Record pharmacist to technician staffing ratios
    - Drug repackaging practices
    - Check expired drug practices
    - Verify compliance with state standards for pharmacy practice

At the conclusion of the audit, the Participating Pharmacy's pharmacist in-charge is given an exit interview that documents the items reviewed.

Within 30 days of the conclusion of each on-site audit, Change Healthcare or its authorized agent submits a written Initial Findings Audit Report comprised of a letter and if applicable an audit worksheet(s) for the on-site audits. The Initial Findings Audit Report details the findings and includes a statement of the total amount reasonably determined by Change Healthcare or its authorized agent to be potentially recoverable from the Participating Pharmacy. The Initial Findings Audit Report shall also provide a summary of the audit findings, the overcharge amount, specific information about the audit (e.g., date, time, credentialing results, etc.), and Claim-level detail for each discrepant Claim.

Thereafter, Participating Pharmacy is provided a structured opportunity to appeal the Initial Findings Audit Report as defined by the Agreement, to redress the documented audit discrepancies.

Following review of the Participating Pharmacy appeal submission, Change Healthcare or its authorized agent will determine the final disposition of the audit results including recommended Claim amount recoveries if applicable. Once audit results are final, a Final Results Audit Report will be communicated to the Participating Pharmacy comprised of a final results letter and if applicable an audit worksheet(s) results post appeal findings for the on-site audits. The Final Results Audit Report details the findings and if applicable includes a statement of the total amount reasonably determined by Change Healthcare or its authorized agent to be recoverable from the Participating Pharmacy and details by Claim for the recovery rationale.

Desk Audits:

A “Desk Audit” is a Participating Pharmacy audit similar to the on-site audit except that it is conducted remotely via mail rather than as an in person on-site audit. During each desk audit, Change Healthcare or its authorized agent audits unique Prescriptions and associated refills. During the desk audit, documentation reviewed may include, but is not limited to:

- Copies of Prescriptions – must include front and back
- Any documentation showing Copayment paid by a Participant
- Signature or if applicable, delivery logs
- Prescription labels
- Compound Drug information – including NDC’s, quantities and ingredients
- Purchase records (wholesaler, manufacturer and vendor invoices)
- License information
- Attestations – as required by, but not limited to, state, federal, regulation or CMS guidance
- Computer records
- Insurance information – includes both pharmacy and pharmacist’s professional liability insurance
- FWA Training

Change Healthcare will provide a due date for submitting documentation. Participating Pharmacy may fax or mail such documentation to the fax number or address identified in the audit letter.

Failure to submit the documentation as requested by the due date may result in full or partial recovery of affected Claims and escalation to an on-site audit or if warranted, termination of the Agreement.

All requested Claims documentation will be reviewed by Change Healthcare or its designated auditor for accuracy to verify Claims are in compliance with the Agreement and the CHPM.

Change Healthcare or its authorized agent auditor will provide a written report with any discrepancies or audit findings.

Mini-Desk Audits:

From time to time, Change Healthcare conducts mini-desk audits. These audits minimize the number of Prescriptions reviewed during a desk audit. The number is usually between 2-10 Prescriptions. Mini-desk audits help identify Claims processing issues that need to be addressed based on a few Prescriptions. Mini-desk audits utilize real time auditing, which is a recovery-focused monthly (or more frequent) electronic review of the most recent set of paid Claims. The Claims are passed through the Change Healthcare audit system, applying criteria that are specifically designed to identify inappropriately billed Claims. Real time queries are built to identify such issues as:

- Pricing

- Day's supply
- Suspect quantities
- Exceeding dispensing limits for controlled substances
- High dollar Claims
- Duplicate Claims
- Package size
- Excessive dose
- Gender/age sensitive medications
- Plan Sponsor specific concerns

Change Healthcare will provide a due date for submitting documentation pursuant to a mini-desk audit. Participating Pharmacy may fax or mail such documentation to the fax number or address identified in the audit letter.

Failure to submit the documentation as requested by the due date may result in full or partial recovery of affected Claims and escalation to an on-site audit or if warranted, termination of the Agreement.

All requested Claims documentation will be reviewed by Change Healthcare for accuracy to verify Claims are in compliance with the Agreement and the CHPM.

Investigative or Expanded Audits:

Based on the discovery of suspected FWA during an audit, there may be a requirement for an additional assessment. Change Healthcare or its authorized agent may conduct a more comprehensive audit that includes an on-site investigative or expanded audit visit to conduct an expanded review of Prescriptions and related refills, expanded signature log verification, patient and/or Prescriber verification letters or other pharmacy related activities deemed necessary to review. The scope of the investigative or expanded audit will be developed in collaboration with our Plan Sponsors and such audit will be targeted to a variety of audit issues such as, but not limited to:

- Random vs targeted Prescription selection
- Time frame the audit will cover
- Plan to address specific issues identified
- Use of expanded signature log verification
- Participant letter verifications
- Prescriber letter verifications
- Participant/Prescriber interviews
- Plan Sponsor onsite visits to Prescribers if deemed necessary
- Purchase invoice review
- At the conclusion of the audit, the Participating Pharmacy's pharmacist in-charge is given an exit interview that documents the items reviewed.

Within 30 days of the conclusion of each investigative/expanded audit, Change Healthcare or its authorized agent will submit a written Initial Findings Audit Report comprised of a letter and if applicable an audit worksheet(s) for the audit. The Initial Findings Audit Report details the findings and includes a statement of the total amount reasonably determined by Change Healthcare or its authorized agent to be potentially recoverable from the Participating Pharmacy. The Initial Findings Audit Report shall also provide a summary of the audit findings, the overcharge amount, specific information about the audit (e.g., date, time, credentialing results, etc.), and Claim-level detail for each discrepant Claim.

Thereafter, the Participating Pharmacy is provided a structured opportunity to appeal the Initial Audit Findings Report to redress the documented audit discrepancies.

Following review of the Participating Pharmacy appeal submission, Change Healthcare or its authorized agent will determine the final disposition of the audit results including recommended Claim amount recoveries, if applicable. Once audit results are final, a Final Audit Findings Report will be communicated to the Participating Pharmacy comprised of a final results letter and if applicable an audit worksheet(s) results post appeal findings for the audit. The Final Audit Findings Report which details the findings and if applicable includes a statement of the total amount reasonably determined by Change Healthcare or its authorized agent to be recoverable from the Participating Pharmacy and details by Claim for the recovery rationale.

Appeals Management:

Upon receipt of the Initial Audit Findings, Pharmacy will have a chance to appeal such findings directly to the auditor. Pharmacies will be given 30 days (or such longer period required by Law) to submit additional documentation to dispute the Initial Audit Findings. Upon completion of the Initial Audit Findings and appeal process, the Participating Pharmacy will receive the Final Audit Findings which will state the resolution of the audit claim and any potential recoupment. If the Participating Pharmacy is not satisfied with the Final Audit Findings, the Participating Pharmacy can appeal to Change Healthcare directly. Change Healthcare requires that any appeal must include a letter addressing the Participating Pharmacy's objection to the Final Audit Findings and auditor's ruling, and why the Participating Pharmacy feels that their appeal should be granted. Any appeal without such information may result in an appeal denial.

Corrective Action Plans.

In the event deficiencies are identified in Participating Pharmacy's compliance with this Agreement, upon Change Healthcare's request, Participating Pharmacy shall provide a written corrective action plan acceptable to Change Healthcare within 14 calendar days. Participating Pharmacy shall immediately implement the corrective action plan and shall provide Change Healthcare with the status of the corrective action plan on a regular basis and upon request. Notwithstanding the foregoing, Change Healthcare and state and federal regulators routinely monitor the level, manner, and quality of Covered Prescription Services provided as well as Participating Pharmacy's compliance with this Agreement. If a deficiency is identified, Change Healthcare or regulator, in its sole discretion, may choose to issue a corrective action plan to Participating Pharmacy. Participating Pharmacy is required to accept and implement such corrective action plan. Participating Pharmacy is not entitled to a corrective action plan prior to any suspension or termination of this Agreement. As a result of any Corrective Action Plan, it may require another visit to confirm actions identified in the CAP were administered and resolved. If such audit is necessary, the cost of the audit will be paid by the Participating Pharmacy. Such funds, at Change Healthcare's discretion, will either be withheld from future ACH payments or payable by check from the Participating Pharmacy to Change Healthcare.

ATTACHMENT 1

Change Healthcare Pharmacy Solutions Letter of Authorization for ACH

This form must be completed before ACH service can commence. Please be sure to sign where indicated and attach a voided check.

NPI:
NCPDP Number:
Pharmacy dba Name:

Account Name:		
Federal Tax ID (T.I.N):		
Address :		City/State/Zip:
Financial Institution	Branch	
City	State	Zip
Transit/Routing/ABA Number †		
Account Number ††		
Mother's Maiden Name or Unique PIN Number **(Used for Identification purposes if changes need to be made)		

As represented by your signature below, you hereby authorize Change Healthcare Pharmacy Solutions to initiate entries to your account indicated above and the financial institution named above, herein called depository, to credit the same to such account. Additionally, you agree that in the event that Change Healthcare Pharmacy Solutions initiates an incorrect entry to your account, it shall be entitled to make prompt corrective and/or mitigating action to correct such error.

Signature:	Date:
Name (print):	Title:

Version date 06.15.18

E-Mail address:	Telephone Number:

This authority shall remain in full force and effect until Change Healthcare Pharmacy Solutions and depository have received written notification from you of its termination in such manner as to afford Change Healthcare Pharmacy Solutions and depository a reasonable opportunity to act prior to changing account. You will receive an HP-auto email notification after any account update.

PLEASE ATTACH A VOIDED CHECK DRAWN ON THE ABOVE ACCOUNT

† Nine-digit number located on the bottom of check. If you need assistance, please contact your bank.
†† Located at bottom of check. If you need assistance, please contact your bank.
** Set up **cannot** be completed until this field is completed.

Return to Change Healthcare Pharmacy Solutions, Attn: Provider Relations
300 Executive Parkway West, Suite 200, Hudson, OH 44236; f: (615) 340-6160; e: Provider.Relations@changehealthcare.com

ATTACHMENT 2
PAYER SHEETS

CHANGE HEALTHCARE
NCPDP VERSION D.0 PAYER SHEET
COMMERCIAL
CLAIM BILLING/CLAIM REBILL (B1/B3)

** Start of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template**

GENERAL INFORMATION

Payer Name: Change HealthCare	Date: 04/04/2018	
Plan Name/Group Name: Change Healthcare Commercial	BIN: 004682	PCN: CN or Varies by Plan refer to Coupon or Card
Plan Name/Group Name: Change Healthcare Commercial	BIN: 600426	PCN: 54 or Varies by Plan refer to Coupon or Card
Plan Name/Group Name: Easy Save Programs	BIN: 016184	PCN: PW
Processor: Change Healthcare		
Effective as of: 04/04/2018	NCPDP Telecommunication Standard Version/Release #: D.Ø	
NCPDP Data Dictionary Version Date: October 2016	NCPDP External Code List Version Date: October 2016	
Contact/Information Source: Pharmacy Helpdesk 800-433-4893 E-mail: SelectRx_Help_Desk@changehealthcare.com		
Certification Testing Window: Certification Not Required		
Provider Relations Help Desk Info: Provider.relations@changehealthcare.com		
Other versions supported: Only D.Ø		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name

FIELD LEGEND FOR COLUMNS

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

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

CLAIM BILLING/CLAIM REBILL TRANSACTION

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

Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	See general information above	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	See above	M	Varies by plan
1Ø9-A9	TRANSACTION COUNT	1-4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 - NPI	M	
2Ø1-B1	SERVICE PROVIDER ID	NPI	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	blank	M	

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

	Insurance Segment **Segment Identification (111-AM) = “Ø4”**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID		R	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. Required if needed for pharmacy claim processing and payment.
3Ø3-C3	PERSON CODE		R	*Imp Guide:* Required if needed to uniquely identify the family members within the Cardholder ID. *Payer Requirement: Same as Implementation guide*
3Ø6-C6	PATIENT RELATIONSHIP CODE		R	*Imp Guide:* Required if needed to uniquely identify the relationship of the Patient to the Cardholder. *Payer Requirement: Same as Implementation guide*

CHANGE HEALTHCARE

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

	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		R	*Imp Guide:* Required when the patient has a first name.
311-CB	PATIENT LAST NAME		R	

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

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	03 - NDC	M	00 if Compound Code (406-D6) = 2
4Ø7-D7	PRODUCT/SERVICE ID	11-digit NDC	M	0 if Compound Code (406-D6) = 2
442-E7	QUANTITY DISPENSED	Format 9(7)V999	R	
4Ø3-D3	FILL NUMBER	New = 00 must be sent	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 = Not a compound 2 = Compound	R	Refer to Compound Segment when Compound Code (406-D6) = 2
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED		R	*Imp Guide:* Required if necessary for plan benefit administration. *Payer Requirement: Same as Implementation guide*
419-DJ	PRESCRIPTION ORIGIN CODE		R	*Imp Guide:* Required if necessary for plan benefit administration. *Payer Requirement: Same as Implementation guide*
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	*Imp Guide:* Required if Submission Clarification Code (42Ø-DK) is used. *Payer Requirement: Same as implementation guide*
42Ø-DK	SUBMISSION CLARIFICATION CODE		RW	*Imp Guide:* Required if clarification is needed and value submitted is greater than zero (Ø). If the Date of Service (4Ø1-D1) contains the subsequent payer coverage date, the Submission Clarification Code (42Ø-DK) is

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				required with value of "19" (Split Billing – indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. Used only in long-term care settings) for individual unit of use medications. *Payer Requirement: Same as Implementation guide*
3Ø8-C8	OTHER COVERAGE CODE	0 = Not Specified by Patient 1 = No Other Coverage 2 = Other Coverage Exists – Payment Collected 3 = Other Coverage Exist – Claim Not Covered 4 = Other Coverage Exist – Payment Collected	RW	*Imp Guide:* Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. *Payer Requirement: Same as Implementation guide* **Requires COB Segment to be sent*
461-EU	PRIOR AUTHORIZATION TYPE CODE	1 = Prior Authorization	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Same as Implementation guide*
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	If Applicable to Rx	RW	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement: Same as Implementation guide*
995-E2	ROUTE OF ADMINISTRATION		RW	*Imp Guide:* Required if specified in trading partner agreement. *Payer Requirement: When compound Code (406 – D6) = 2*

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

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
433-DX	PATIENT PAID AMOUNT SUBMITTED		R	*Imp Guide:* Required if this field could result in different coverage, pricing, or patient financial responsibility.
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	*Imp Guide:* Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. *Payer Requirement: Same as Implementation guide*
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		RW	*Imp Guide:* Required if Other Amount Claimed Submitted (48Ø-H9) is used. *Payer Requirement: Same as Implementation guide*

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Implementation guide*
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Implementation guide*
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		RW	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement: Same as Implementation guide*
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		RW	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). *Payer Requirement: Same as Implementation guide*
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		RW	*Imp Guide:* Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). *Payer Requirement: Same as Implementation guide*
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement.
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	*Imp Guide:* Required if needed for receiver claim/encounter adjudication.

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

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	01 = NPI 12 = DEA	R	*Imp Guide:* Required if Prescriber ID (411-DB) is used.

CHANGE HEALTHCARE

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
411-DB	PRESCRIBER ID		R	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs.
427-DR	PRESCRIBER LAST NAME		RW	*Imp Guide:* Required when the Prescriber ID (411-DB) is not known. Required if needed for Prescriber ID (411-DB) validation/clarification. *Payer Requirement: Required when submitting DEA*
364-2J	PRESCRIBER FIRST NAME		RW	*Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Required When submitting DEA
365-2K	PRESCRIBER STREET ADDRESS		RW	*Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement: Required when submitting DEA*
366-2M	PRESCRIBER CITY ADDRESS		RW	*Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement: Required when submitting DEA*
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS		RW	*Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement: Required when submitting DEA*
368-2P	PRESCRIBER ZIP/POSTAL ZONE		RW	*Imp Guide:* Required if needed to assist in identifying the prescriber. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement: Required When submitting DEA*

CHANGE HEALTHCARE

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	Required only for secondary, Tertiary, etc. claims Other Coverage Code (308-C8) = 0, 1, 3

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** Scenario 1 - Other Payer Amount Paid Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	03 = BIN	R	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID	Bin Number	R	*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement: Other Payer BIN*
443-E8	OTHER PAYER DATE		RW	*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER		RW	*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used.
431-DV	OTHER PAYER AMOUNT PAID		M	*Imp Guide:* Required if other payer has approved payment for some/all of the billing.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE		RW	*Imp Guide:* Required when the other payer has denied the payment for the billing. *Payer Requirement: Required when the Other Payer has denied for the billing designated with Other Coverage Code (308 – C8) = 3*

Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary etc.. OPPRA
Scenario 1 - Other Payer Amount Paid Repetitions Only	X	Required only for secondary, Tertiary, etc. claims Other Coverage Code (308-C8) = 3, 8

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER	03 - BIN		*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used.

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
34Ø-7C	OTHER PAYER ID	BIN		*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication.
443-E8	OTHER PAYER DATE			*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE			*Imp Guide:* Required when the other payer has denied the payment for the billing.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.		*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT			*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted..

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	R	*Imp Guide:* Required if DUR/PPS Segment is used.
439-E4	REASON FOR SERVICE CODE		R	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.
44Ø-E5	PROFESSIONAL SERVICE CODE		R	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.
441-E6	RESULT OF SERVICE CODE		R	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.
474-8E	DUR/PPS LEVEL OF EFFORT		R	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.
475-J9	DUR CO-AGENT ID QUALIFIER		R	*Imp Guide:* Required if DUR Co-Agent ID (476-H6) is used.
476-H6	DUR CO-AGENT ID		R	*Imp Guide:* Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service.

DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	For use to define professional services or override clinical edits

Compound Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when Compound Code (406-D6) = 2

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	

	Compound Segment Segment Identification (111-AM) = “1Ø”			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	03 - NDC	M	
489-TE	COMPOUND PRODUCT ID	11 digit NDC	M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST			*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed.

**** End of Request Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template****

**** Start of Request Claim Reversal (B2) Payer Sheet Template****

Claim Reversal (B2) NCPDP Version D.0

GENERAL INFORMATION

Payer Name: Change Healthcare	Date: 04/04/2018	
Plan Name/Group Name: Change Healthcare Commercial	BIN:004682	PCN: CN or Varies by Plan refer to Coupon or Card
Plan Name/Group Name: Change Healthcare Commercial	BIN:600426	PCN: 54 or Varies by Plan refer to Coupon or Card
Plan Name/Group Name: Easy Save Programs	BIN:016184	PCN: PW

FIELD LEGEND FOR COLUMNS

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

Question	Answer
What is your reversal window? (If transaction is billed today what is the timeframe for reversal to be submitted?)	Varies by plan

CLAIM REVERSAL TRANSACTION

The following lists the segments and fields in a Claim Reversal Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

CHANGE HEALTHCARE

Transaction Header Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used		

	Transaction Header Segment			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	See above	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	Varies by Plan	M	
1Ø9-A9	TRANSACTION COUNT	1-4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	All Spaces	M	

Claim Segment Questions	Check	Claim Reversal If Situational, *Payer Situation*
This Segment is always sent	X	

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Reversal**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	03=NDC	M	
4Ø7-D7	PRODUCT/SERVICE ID	11-digit NDC	M	
4Ø3-D3	FILL NUMBER	New = 00		*Imp Guide:* Required if needed for reversals when multiple fills of the same Prescription/Service Reference Number (4Ø2-D2) occur on the same day.
3Ø8-C8	OTHER COVERAGE CODE		M	*Imp Guide:* Required if needed by receiver to match the claim that is being reversed. *Payer Requirement:* Must match original claim being reversed.
147-U7	pharmacy service type			*Imp Guide:* Required when the submitter must clarify the type of services being performed as a condition for proper reimbursement by the payer.
337-4C	Coordination of Benefits/Other Payments Count	Maximum count of 9.	M	
338-5C	Other Payer Coverage Type		M	

**** End of Request Claim Reversal (B2) Payer Sheet Template****

CLAIM BILLING/CLAIM REBILL ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

** Start of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template**

GENERAL INFORMATION

Payer Name: Change HealthCare	Date: 04/04/2018	
Plan Name/Group Name: Change Healthcare Commercial	BIN: 004682	PCN: CN or Varies by Plan refer to Coupon or Card
Plan Name/Group Name: Change Healthcare Commercial	BIN: 600426	PCN: 54 or Varies by Plan refer to Coupon or Card

CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	*Provide general information when used for transmission-level messaging.*

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail. *Payer Requirement: Same as implementation Guide*

CHANGE HEALTHCARE

Response Insurance Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Response Insurance Segment **Segment Identification (111-AM) = "25"**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
545-2F	NETWORK REIMBURSEMENT ID			*Imp Guide:* Required if needed to identify the network for the covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist. *Payer Requirement: Same as implementation Guide*

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement: Same as implementation Guide*
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement: Same as implementation Guide*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used. *Payer Requirement: Same as implementation Guide*

CHANGE HEALTHCARE

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail. *Payer Requirement: Same as implementation Guide*
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current. *Payer Requirement: Same as implementation Guide*
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement: Same as implementation Guide*
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number to the receiver. *Payer Requirement: Same as implementation Guide*

Response Claim Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

CHANGE HEALTHCARE

Response Pricing Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT		R	
5Ø6-F6	INGREDIENT COST PAID		R	
5Ø7-F7	DISPENSING FEE PAID		R	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. *Payer Requirement: Same as implementation Guide*
557-AV	TAX EXEMPT INDICATOR		RW	*Imp Guide:* Required if the sender (health plan) and/or patient is tax exempt and exemption applies to this billing. *Payer Requirement: Same as implementation Guide*
558-AW	FLAT SALES TAX AMOUNT PAID		RW	*Imp Guide:* Required if Flat Sales Tax Amount Submitted (481-HA) is greater than zero (Ø) or if Flat Sales Tax Amount Paid (558-AW) is used to arrive at the final reimbursement. *Payer Requirement: Same as implementation Guide*
559-AX	PERCENTAGE SALES TAX AMOUNT PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Percentage Sales Tax Amount Submitted (482-GE) is greater than zero (Ø). Required if Percentage Sales Tax Rate Paid (56Ø-AY) and Percentage Sales Tax Basis Paid (561-AZ) are used. *Payer Requirement: Same as implementation Guide*
56Ø-AY	PERCENTAGE SALES TAX RATE PAID		RW	*Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø). *Payer Requirement: Same as implementation Guide*

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
561-AZ	PERCENTAGE SALES TAX BASIS PAID		RW	*Imp Guide:* Required if Percentage Sales Tax Amount Paid (559-AX) is greater than zero (Ø). *Payer Requirement: Same as implementation Guide*
521-FL	INCENTIVE AMOUNT PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Incentive Amount Submitted (438-E3) is greater than zero (Ø). *Payer Requirement: Same as implementation Guide*
563-J2	OTHER AMOUNT PAID COUNT	Maximum count of 3.	RW	*Imp Guide:* Required if Other Amount Paid (565-J4) is used. *Payer Requirement: Same as implementation Guide*
564-J3	OTHER AMOUNT PAID QUALIFIER		RW	*Imp Guide:* Required if Other Amount Paid (565-J4) is used. *Payer Requirement: Same as implementation Guide*
565-J4	OTHER AMOUNT PAID		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Other Amount Claimed Submitted (48Ø-H9) is greater than zero (Ø). *Payer Requirement: Same as implementation Guide*
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported. *Payer Requirement: Same as implementation Guide*
5Ø9-F9	TOTAL AMOUNT PAID		R	

CHANGE HEALTHCARE

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		R	*Imp Guide:* Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing. *Payer Requirement: Same as implementation Guide*
523-FN	AMOUNT ATTRIBUTED TO SALES TAX		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes sales tax that is the financial responsibility of the member but is not also included in any of the other fields that add up to Patient Pay Amount. *Payer Requirement: Same as implementation Guide*
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes deductible *Payer Requirement:* (any unique payer requirement(s))
518-FI	AMOUNT OF COPAY		R	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. *Payer Requirement: Same as implementation Guide*
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE		RW	*Imp Guide:* Required if the customer is responsible for 1ØØ% of the prescription payment and when the provider net sale is less than the amount the customer is expected to pay. *Payer Requirement: Same as implementation Guide*
575-EQ	PATIENT SALES TAX AMOUNT		RW	*Imp Guide:* Used when necessary to identify the Patient's portion of the Sales Tax. Provided for informational purposes only. *Payer Requirement: Same as implementation Guide*

CHANGE HEALTHCARE

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
574-2Y	PLAN SALES TAX AMOUNT		RW	*Imp Guide:* Used when necessary to identify the Plan's portion of the Sales Tax. Provided for informational purposes only. *Payer Requirement: Same as implementation Guide*
572-4U	AMOUNT OF COINSURANCE		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes coinsurance as patient financial responsibility. *Payer Requirement: Same as implementation Guide*
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a cost share differential due to the selection of one pharmacy over another *Payer Requirement: Same as implementation Guide*
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand drug. *Payer Requirement: Same as implementation Guide*
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a non-preferred formulary product. *Payer Requirement: Same as implementation Guide*
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION		RW	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes an amount that is attributable to a patient's selection of a Brand non-preferred formulary product. *Payer Requirement: Same as implementation Guide*

	Response Pricing Segment Segment Identification (111-AM) = "23"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
148-U8	INGREDIENT COST CONTRACTED/REIMBURSABLE AMOUNT		RW	*Imp Guide:* Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. *Payer Requirement: Same as implementation Guide*
149-U9	DISPENSING FEE CONTRACTED/REIMBURSABLE AMOUNT		RW	*Imp Guide:* Required when Basis of Reimbursement Determination (522-FM) is "14" (Patient Responsibility Amount) or "15" (Patient Pay Amount) unless prohibited by state/federal/regulatory agency. *Payer Requirement: Same as implementation Guide*

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	*Imp Guide:* Required if Reason For Service Code (439-E4) is used. *Payer Requirement: Same as implementation Guide*
439-E4	REASON FOR SERVICE CODE		RW	*Imp Guide:* Required if utilization conflict is detected. *Payer Requirement: Same as implementation Guide*
528-FS	CLINICAL SIGNIFICANCE CODE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement: Same as implementation Guide*

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
529-FT	OTHER PHARMACY INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement: Same as implementation Guide*
53Ø-FU	PREVIOUS DATE OF FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used. *Payer Requirement: Same as implementation Guide*
531-FV	QUANTITY OF PREVIOUS FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used. *Payer Requirement: Same as implementation Guide*
532-FW	DATABASE INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement: Same as implementation Guide*
533-FX	OTHER PRESCRIBER INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement: Same as implementation Guide*
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement: Same as implementation Guide*
57Ø-NS	DUR ADDITIONAL TEXT		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. *Payer Requirement: Same as implementation Guide*

Response Coordination of Benefits/Other Payers Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	

	Response Coordination of Benefits/Other Payers Segment Segment Identification (111-AM) = "28"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
355-NT	OTHER PAYER ID COUNT	Maximum count of 3.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER		RW	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits.
992-MJ	OTHER PAYER GROUP ID		RW	*Imp Guide:* Required if other insurance information is available for coordination of benefits.

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Message Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational		

	Response Message Segment Segment Identification (111-AM) = "2Ø"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail.

Response Insurance Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational		

	Response Insurance Segment Segment Identification (111-AM) = "25"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
545-2F	NETWORK REIMBURSEMENT ID		RW	*Imp Guide:* Required if needed to identify the network for the covered member. Required if needed to identify the actual Network Reimbursement ID, when applicable and/or available. Required to identify the actual Network Reimbursement ID that was used when multiple Network Reimbursement IDs exist.

Response Status Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER			*Imp Guide:* Required if needed to identify the transaction.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.
987-MA	URL		RW	*Imp Guide:* Provided for informational purposes only to relay health care communications via the Internet.

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

	Response Claim Segment **Segment Identification (111-AM) = "22"**			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
556-AU	PREFERRED PRODUCT DESCRIPTION			*Imp Guide:* Required if a product preference exists that either cannot be communicated by the Preferred Product ID (553-AR) or to clarify the Preferred Product ID (553-AR).

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

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	RW	*Imp Guide:* Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		RW	*Imp Guide:* Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used.
532-FW	DATABASE INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
57Ø-NS	DUR ADDITIONAL TEXT		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.

CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

CLAIM BILLING/CLAIM REBILL REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Rejected/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

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

	Response Message Segment **Segment Identification (111-AM) = “2Ø”**			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø4-F4	MESSAGE		RW	*Imp Guide:* Required if text is needed for clarification or detail.

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

	Response Status Segment **Segment Identification (111-AM) = “21”**			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	*Imp Guide:* Required if needed to identify the transaction.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.

CHANGE HEALTHCARE

	Response Status Segment Segment Identification (111-AM) = “21”			**Claim Billing/Claim Rebill Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		RW	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		RW	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

**** End of Response Claim Billing/Claim Rebill (B1/B3) Payer Sheet Template****