HDR

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"HDR"
2	SUBMITTER ID		4 - 9	X(6)	6	CMS	Unique ID assigned by CMS.
3	FILE ID		10 - 19	X(10)	10	PDFS	Unique ID provided by Submitter. Same ID cannot be used within 12 months.
4	TRANS DATE		20 - 27	9(8)	8	PDFS	Date of file transmission to PDFS.
5	PROD TEST CERT IND		28 - 31	X(4)	4	PDFS	PROD, TEST, or CERT
6	FILLER		32 - 512	X(481)	481	N/A	SPACES

BHD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"BHD"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CONTRACT NO		11 - 15	X(5)	5	CMS	Assigned by CMS
4	PBP ID		16 - 18	X(3)	3	CMS	Assigned by CMS
5	FILLER		19 - 512	X(494)	494	N/A	SPACES

DET

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CLAIM CONTROL NUMBER		11 - 50	X(40)	40	CMS	Optional Field
4	Medicare beneficiary identifier		51 - 70	X(20)	20	CMS	Medicare Health Insurance Claim Number (HICN) or Railroad Retirement Board (RRB) number or Medicare Beneficiary Identifier (MBI).
5	CARDHOLDER ID	302-C2	71 - 90	X(20)	20	NCPDP	Plan identification of the enrollee. Assigned by plan.
6	PATIENT DATE OF BIRTH (DOB)	304-C4	91 - 98	9(8)	8	NCPDP	CCYYMMDD Optional Field
7	PATIENT GENDER CODE	305-C5	99 - 99	9(1)	1	NCPDP	1 = M 2 = F Unspecified or unknown values are not accepted
8	DATE OF SERVICE (DOS)	401-D1	100 - 107	9(8)	8	NCPDP	CCYYMMDD
9	PAID DATE		108 - 115	9(8)	8	CMS	CCYYMMDD. The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans.
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 - 127	9(12)	12	NCPDP	The field length of 12 will be implemented in DDPS on January 1, 2011 in anticipation of the implementation of the NCPDP D.0 standard in 2012 . Field will be right justified and filled with 5 leading zeroes. Applies to all PDEs submitted January 1, 2011 and after.
11	FILLER		128 - 129	X(2)	2	N/A	SPACES
12	PRODUCT SERVICE ID	407-D7 or 489-TE	130 - 148	X(19)	19	NCPDP	Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 8 spaces. Format is MMMMMDDDDPP. DDPS will reject the following billing codes for compounded legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
13	SERVICE PROVIDER ID QUALIFIER	202-B2	149 - 150	X(2)	2	NCPDP	The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number 99 = Other (Reported Gap Discount must = 0) Mandatory for standard format. For standard format, valid values are 01 - NPI or 07 - NCPDP Provider ID. For non-standard format any of the above values are acceptable.
14	SERVICE PROVIDER ID	201-B1	151 - 165	X(15)	15	NCPDP	When Plans report Service Provider ID Qualifier = “99” - Other, populate Service Provider ID with the default value “PAPERCLAIM” defined for TrOOP Facilitation Contract. When Plans report Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report embedded dashes).
15	FILL NUMBER	403-D3	166 - 167	9(2)	2	NCPDP	Values = 0 - 99.
16	DISPENSING STATUS	343-HD	168 - 168	X(1)	1	NCPDP	On PDEs with DOS on or after January 1, 2011, must be blank. On PDEs with DOS prior to January 1, 2011, valid values are: Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
17	COMPOUND CODE	406-D6	169 - 169	9(1)	1	NCPDP	0=Not specified 1=Not a Compound 2=Compound

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	408-D8	170 - 170	X(1)	1	NCPDP	0=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed - Patient Requested Product Dispensed 3=Substitution Allowed - Pharmacist Selected Product Dispensed 4=Substitution Allowed - Generic Drug Not in Stock 5=Substitution Allowed - Brand Drug Dispensed as Generic 6=Override 7=Substitution Not Allowed - Brand Drug Mandated by Law 8=Substitution Allowed Generic Drug Not Available in Marketplace 9=Other
19	QUANTITY DISPENSED	442-E7	171 - 180	9(7)V999	10	NCPDP	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
20	FILLER		181 - 182	X(2)	2	N/A	SPACES
21	DAYS SUPPLY	405-D5	183 - 185	9(3)	3	NCPDP	0 – 999
22	PRESCRIBER ID QUALIFIER	466-EZ	186 - 187	X(2)	2	NCPDP	The type of prescriber identifier used in field 23. Prior to January 1, 2013: 01 = National Provider Identifier (NPI) 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number Mandatory for standard format. Mandatory for Non-Standard Format with DOS => 1/1/2012 For DOS <1/1/2012, Optional when Non-Standard Format Code = "B", "C", "P", or "X" but must be valid value if present. As of January 1, 2013, 01 = NPI is mandatory for all formats
23	PRESCRIBER ID	411-DB	188 - 202	X(15)	15	NCPDP	Mandatory

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
24	DRUG COVERAGE STATUS CODE		203 - 203	X(1)	1	CMS	Coverage status of the drug under Part D and/or the PBP. C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
25	ADJUSTMENT DELETION CODE		204 - 204	X(1)	1	CMS	A = Adjustment D = Deletion Blank = Original PDE
26	NON- STANDARD FORMAT CODE		205 - 205	X(1)	1	CMS	Format of claims originating in a non-standard format. B = Beneficiary submitted claim C = COB claim P = Paper claim from provider X = X12 837 Blank = NCPDP electronic format
27	PRICING EXCEPTION CODE		206 - 206	X(1)	1	CMS	M= Medicare as Secondary Payer O = Out-of-network pharmacy (Medicare is Primary) Blank = In-network pharmacy (Medicare is Primary)
28	CATASTROPHIC COVERAGE CODE		207 - 207	X(1)	1	CMS	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. Valid values are: A = Attachment Point met on this event C = Above Attachment Point Blank = Attachment Point not met
29	INGREDIENT COST PAID	506-F6	208 - 215	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.
30	DISPENSING FEE PAID	507-F7	216 - 223	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee reported in Field 41.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
31	TOTAL AMOUNT ATTRIBUTED TO SALES TAX		224 - 231	S9(6)V99	8	CMS	Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report the total sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.
32	GROSS DRUG COST BELOW OUT- OF-POCKET THRESHOLD (GDCB)		232 - 239	S9(6)V99	8	CMS	Reports covered drug cost at or below the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCA. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = blank, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling at or below the OOP threshold. Any remaining portion is reported in GDCA. This amount increments the Total Gross Covered Drug Cost Accumulator amount.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
33	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)		240 - 247	S9(6)V99	8	CMS	Reports covered drug cost above the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCB. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee above the OOP threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling above the OOP threshold. Any remaining portion is reported in GDCB. This amount increments the Total Gross Covered Drug Cost Accumulator amount.
34	PATIENT PAY AMOUNT	505-F5	248 - 255	S9(6)V99	8	NCPDP	Payments made by the beneficiary or by family or friends at point of sale. This amount increments the True Out-of-Pocket Accumulator amount.
35	OTHER TROOP AMOUNT		256 - 263	S9(6)V99	8	CMS	Other health insurance payments by TrOOP-eligible other payers (e.g. SPAPs). This field records all third party payments that contribute to a beneficiary's TrOOP except LICS, Patient Pay Amount, and Reported Gap Discount. This amount increments the True Out-of-Pocket Accumulator amount.
36	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS)		264 - 271	S9(6)V99	8	CMS	Amount the plan advanced at point-of-sale due to a beneficiary's LI status. This amount increments the True Out-of-Pocket Accumulator amount.
37	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)		272 - 279	S9(6)V99	8	CMS	Amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers: group health plans, governmental programs (e.g. VA, TRICARE), Workers' Compensation, Auto/No-Fault/Liability Insurances.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
38	COVERED D PLAN PAID AMOUNT (CPP)		280 - 287	S9(6)V99	8	CMS	The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing and Over-the-Counter drugs are excluded from this field.
39	NON COVERED PLAN PAID AMOUNT (NPP)		288 - 295	S9(6)V99	8	CMS	The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is excluded from risk corridor calculations.
40	ESTIMATED REBATE AT POS		296 - 303	S9(6)V99	8	CMS	The estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical manufacturer or other entity.
41	VACCINE ADMINISTRATION FEE		304 - 311	S9(6)V99	8	CMS	The amount reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee.
42	PRESCRIPTION ORIGIN CODE	419-DJ	312 - 312	X(1)	1	NCPDP	Required on PDEs with DOS January 1, 2010 and forward. Valid values are: “1” = Written “2” = Telephone “3” = Electronic “4” = Facsimile "5" = Pharmacy On PDEs with DOS prior to January 1, 2010, “0” = Not Specified and blank are also allowed.
43	DATE ORIGINAL CLAIM RECEIVED		313 - 320	9(8)	8	CMS	Date sponsor received original claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros. Required for all LI NET PDEs submitted January 1, 2011 and after, regardless of DOS.
44	CLAIM ADJUDICATION BEGAN TIMESTAMP		321 - 346	X(26)	26	CMS	Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR		347 - 355	S9(7)V99	9	CMS	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
46	TRUE OUT-OF-POCKET ACCUMULATOR		356 - 363	S9(6)V99	8	CMS	Sum of beneficiary's incurred costs (Patient Pay Amount, LICS, Other TrOOP Amount, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
47	BRAND/GENERIC CODE		364 - 364	X(1)	1	CMS	Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. B - Brand G - Generic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
48	BEGINNING BENEFIT PHASE		365 - 365	X(1)	1	CMS	Plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
49	ENDING BENEFIT PHASE		366 - 366	X(1)	1	CMS	Plan-defined benefit phase in effect upon the sponsor completing adjudication of the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
50	REPORTED GAP DISCOUNT		367 - 374	S9(6)V99	8	CMS	The reported amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011 must be blank or zeros. This amount increments the True Out-of-Pocket Accumulator amount.
51	TIER		375 - 375	X(1)	1	CMS	Formulary tier in which the sponsor adjudicated the claim. Values = 1-6 or space. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
52	FORMULARY CODE		376 - 376	X(1)	1	CMS	Indicates if the drug is on the plan's formulary. F - Formulary N - Non-Formulary Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
53	OAP Indicator		377 - 377	X(1)	1	CMS	This is a placeholder field related to Prescriber ID editing. Field should be blank until further notice. Note: This replaced Gap Discount Plan Override Code on 5/15/2016.
54	Pharmacy Service Type		378 - 379	X(2)	2	CMS	Required on PDEs with DOS February 28, 2013 and forward. Valid values are: 01 – Community/Retail Pharmacy Services 02 – Compounding Pharmacy Services 03 – Home Infusion Therapy Provider Services 04 – Institutional Pharmacy Services 05 – Long Term Care Pharmacy Services 06 – Mail Order Pharmacy Services 07 – Managed Care Organization Pharmacy Services 08 – Specialty Care Pharmacy Services 99 - Other For DOS on or before February 27, 2013, can be spaces or any of the valid values listed above. For COB PDEs, can be spaces or any of the valid values listed above.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
55	Patient Residence		380 - 381	X(2)	2	CMS	Required on PDEs with DOS February 28, 2013 and forward. Valid values are: 00 – Not specified, other patient residence not identified below 01 – Home 03 – Nursing Facility 04 – Assisted Living Facility 06 – Group Home 09 – Intermediate Care Facility/Mentally Retarded 11 – Hospice For DOS on or before February 27, 2013, can be spaces or any of the valid values listed above. For COB PDEs, can be spaces or any of the valid values listed above.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
56	Submission Clarification Code		382 - 383	X(2)	2	CMS	For PDEs with DOS February 28, 2013 and forward IF Patient Residence is "03", valid values are: Spaces 16 – Long Term Care (LTC) emergency box or automated dispensing machine 21 – LTC dispensing, 14 days or less not applicable 22 – LTC dispensing, 7 day supply 23 – LTC dispensing, 4 day supply 24 – LTC dispensing, 3 day supply 25 – LTC dispensing, 2 day supply 26 – LTC dispensing, 1 day supply 27 – LTC dispensing, 4 day, then 3 day supply 28 – LTC dispensing, 2 day, then 2 day, then 3 day supply 29 – LTC dispensing, daily during the week then multiple days for weekend 30 – LTC dispensing, per shift 31 – LTC dispensing, per med pass 32 – LTC dispensing, PRN on demand 33 – LTC dispensing, other 7 day or less cycle 34 – LTC dispensing, 14 day supply 35 – LTC dispensing, other 8-14 day dispensing not listed above 36 – LTC dispensing, outside short cycle, determined to be Medicare Part D after originally submitted to another payer For all other cases, field must be spaces .
57	Adjustment Reason Code Qualifier		384 - 384	X(1)	1	CMS	The type of Adjustment Reason Code used in field 58: 2 - CMS Audit 3 - CMS Identified Overpayment (CIO) 4 - CGDP Dispute or Appeal 9 - Other BLANK - Not Applicable The Adjustment Reason Code Qualifier of ‘1’ has been removed from the list of valid values for PDEs for all dates of service submitted on or after 11/13/2016.

1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
58	Adjustment Reason Code		385 - 396	X(12)	12	CMS	This code will assist CMS to track the reason for an adjustment or deletion. Accepted values are dependent upon the qualifier submitted in field 57 Where qualifier... Accepted value is: 2 'OFM', 'RAC', or 'MEDIC' * 3 'CIO' * 4 'DISPUTE' or 'APPEAL' * 9 For future use at CMS' direction BLANK BLANK
59	Type of Fill Code		397 - 397	X(1)	1	CMS	This is a placeholder field related to Prescriber ID editing. Field should be blank until further notice.
60	FILLER		398 - 512	X(115)	115	CMS	SPACES

Notes:

For any field that references NCPDP values, please refer to the appropriate NCPDP specification to ensure compliance.

All dollar fields are mandatory. If the field is not applicable, report a default value of zeroes. Since the field is a signed field, plans must utilize the appropriate overpunch signs as specified in the *NCPDP Telecommunications Standard, Version 5.1*.

BTR

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"BTR"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must match BHD. Must start with 0000001.
3	CONTRACT NO		11 - 15	X(5)	5	CMS	Must match BHD
4	PBP ID		16 - 18	X(3)	3	CMS	Must match BHD
5	DET RECORD TOTAL		19 - 25	9(7)	7	CMS	Total count of DET records
6	FILLER		26 -512	X(487)	487	CMS	SPACES

TLR

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"TLR"
2	SUBMITTER ID		4 - 9	X(6)	6	CMS	Must match HDR
3	FILE ID		10 - 19	X(10)	10	PDFS	Must match HDR
4	TLR BHD RECORD TOTAL		20 - 28	9(9)	9	CMS	Total count of BHD records
5	TLR DET RECORD TOTAL		29 - 37	9(9)	9	CMS	Total count of DET records
6	FILLER		38 -512	X(475)	475	CMS	SPACES

Note:

Maximum number of detail records per file is 3 million records. If one file contains multiple batches, maximum record count applies to the cumulative total across all batches.