FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SUBMITTER ID	4-9	X(6)	6
3	FILE ID	10-19	X(10)	10
4	TRANS DATE	20-27	9(8)	8
5	PROD TEST CERT IND	28-31	X(4)	4
6	DDPS SYSTEM DATE	32-39	9(8)	8
7	DDPS SYSTEM TIME	40-45	9(6)	6
8	DDPS REPORT ID	46-50	X(5)	5
9	FILLER	51-1000	X(950)	950

DEFINITION / VALUES
"HDR"
Unique ID assigned by CMS.
Unique ID provided by Submitter.
Date of file transmission to PDFS.
PROD, TEST, TS1K, CERT, or CT1K
CCYYMMDD = DDPS file creation date
HHMMSS = DDPS file creation time
DDPS report identifier (Always '01'). Field is right-padded with spaces.
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SEQUENCE NO	4-10	9(7)	7
3	CONTRACT NO	11-15	X(5)	5
4	PBP ID	16-18	X(3)	3
5	DDPS SYSTEM DATE	19-26	9(8)	8
6	DDPS SYSTEM TIME	27-32	9(6)	6
7	DDPS REPORT ID	33-37	X(5)	5
8	FILLER	38-1000	X(963)	963

DEFINITION / VALUES
"BHD"
Must start with 0000001
Contract Number from submitted batch
Plan Benefit Package (PBP) ID from submitted batch
CCYYMMDD = DDPS file creation date
HHMMSS = DDPS file creation time
DDPS report identifier (Always '01'). Field is right-padded with spaces.
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1 - 3	X(3)	3
2	SEQUENCE NO	4 - 10	9(7)	7
3	CLAIM CONTROL NUMBER	11 - 50	X(40)	40
4	MEDICARE BENEFICIARY IDENTIFIER	51 - 70	X(20)	20
5	CARDHOLDER ID	71 - 90	X(20)	20
6	PATIENT DATE OF BIRTH (DOB)	91 - 98	9(8)	8
7	PATIENT GENDER CODE	99 - 99	9(1)	1
8	DATE OF SERVICE (DOS)	100 - 107	9(8)	8
9	PAID DATE	108 - 115	9(8)	8
10	PRESCRIPTION SERVICE REFERENCE NO	116 - 127	9(12)	12
11	PRODUCT SERVICE ID	128 - 167	X(40)	40
12	FILLER	168 - 197	X(30)	30
13	SERVICE PROVIDER ID QUALIFIER	198 - 199	X(2)	2
14	SERVICE PROVIDER ID	200 - 214	X(15)	15
15	FILL NUMBER	215 - 216	9(2)	2
16	**FILLER**	**217 - 217**	**X(1)**	**1**
17	COMPOUND CODE	218 - 218	9(1)	1

18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	219 - 219	X(1)	1
19	ORIGINALLY PRESCRIBED QUANTITY	220 - 229	9(7)V999	10
20	QUANTITY DISPENSED	230 - 239	9(7)V999	10
21	FILLER	240 - 242	X(3)	3
22	DAYS SUPPLY	243 - 245	9(3)	3
23	PRESCRIBER ID QUALIFIER	246 - 247	X(2)	2
24	PRESCRIBER ID	248 - 282	X(35)	35
25	DRUG COVERAGE STATUS CODE	283 - 283	X(1)	1
26	ADJUSTMENT DELETION CODE	284 - 284	X(1)	1

27	NON- STANDARD FORMAT CODE	285 - 285	X(1)	1
28	PRICING EXCEPTION CODE	286 - 286	X(1)	1
29	PART D MODEL INDICATOR	287 - 288	X(2)	2
30	MEDICARE PRESCRIPTION PAYMENT PLAN INDICATOR	289 - 289	X(1)	1
31	FILLER	290 - 314	X(25)	25
32	CATASTROPHIC COVERAGE CODE	315 - 315	X(1)	1
33	INGREDIENT COST PAID	316 - 326	S9(9)V99	11
34	DISPENSING FEE PAID	327 - 337	S9(9)V99	11
35	TOTAL AMOUNT ATTRIBUTED TO SALES TAX	338 - 348	S9(9)V99	11

36	ESTIMATED REMUNERATION AT POS AMOUNT (ERPOSA)	349 - 359	S9(9)V99	11
37	PHARMACY PRICE CONCESSIONS AT POS	360 - 370	S9(9)V99	11
38	VACCINE ADMINISTRATION FEE OR ADDITIONAL DISPENSING FEE	371 - 381	S9(9)V99	11
39	FILLER	382 - 436	X(55)	55
40	GROSS DRUG COST BELOW OUT-OF-POCKET THRESHOLD (GDCB)	437 - 447	S9(9)V99	11
41	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)	448 - 458	S9(9)V99	11
42	PATIENT PAY AMOUNT	459 - 469	S9(9)V99	11

43	OTHER TROOP AMOUNT	470 - 480	S9(9)V99	11
44	LOW INCOME COST SHARING SUBSIDY AMOUNT (LICS)	481 - 491	S9(9)V99	11
45	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)	492 - 502	S9(9)V99	11
46	COVERED D PLAN PAID AMOUNT (CPP)	503 - 513	S9(9)V99	11
47	NON COVERED PLAN PAID AMOUNT (NPP)	514 - 524	S9(9)V99	11
48	**SELECTED DRUG SUBSIDY**	525 - 535	S9(9)V99	11
49	REPORTED MANUFACTURER DISCOUNT	536 - 546	S9(9)V99	11
50	REPORTED GAP DISCOUNT	547 - 557	S9(9)V99	11
51	FILLER	558 - 623	X(66)	66
52	TOTAL GROSS COVERED DRUG COST ACCUMULATOR	624 - 634	S9(9)V99	11
53	FILLER	635 - 636	X(2)	2
54	TRUE OUT-OF-POCKET ACCUMULATOR	637 - 647	S9(9)V99	11
55	FILLER	648 -660	X(13)	13
56	OTHER TROOP AMOUNT INDICATOR	661 - 661	X(1)	1

57	BEGINNING BENEFIT PHASE	662 - 662	X(1)	1
58	ENDING BENEFIT PHASE	663 - 663	X(1)	1
59	PRESCRIPTION ORIGIN CODE	664 - 664	X(1)	1
60	DATE ORIGINAL CLAIM RECEIVED	665 - 672	9(8)	8
61	CLAIM ADJUDICATION BEGAN TIMESTAMP	673 - 698	X(26)	26
62	BRAND/GENERIC CODE	699 - 699	X(1)	1
63	TIER	700 - 700	X(1)	1

64	FORMULARY CODE	701 - 701	X(1)	1
65	PHARMACY SERVICE TYPE	702 - 703	X(2)	2
66	PATIENT RESIDENCE	704 - 705	X(2)	2
67	SUBMISSION TYPE CODE 1	706 - 707	X(2)	2
68	SUBMISSION TYPE CODE 2	708 - 709	X(2)	2

69	SUBMISSION TYPE CODE 3	710 - 711	X(2)	2
70	SUBMISSION TYPE CODE 4	712 - 713	X(2)	2
71	SUBMISSION TYPE CODE 5	714 - 715	X(2)	2

72	SUBMISSION CLARIFICATION CODE 1	716 - 718	X(3)	3

73	SUBMISSION CLARIFICATION CODE 2	719 - 721	X(3)	3

74	SUBMISSION CLARIFICATION CODE 3	722 - 724	X(3)	3

75	SUBMISSION CLARIFICATION CODE 4	725 - 727	X(3)	3

76	SUBMISSION CLARIFICATION CODE 5	728 - 730	X(3)	3

77	LTPAC DISPENSE FREQUENCY	731 - 732	X(2)	2
78	ADJUSTMENT REASON CODE QUALIFIER	733 - 733	X(1)	1

79	ADJUSTMENT REASON CODE	734 - 745	X(12)	12
80	FILLER	746 - 829	X(84)	84
81	CMS CALCULATED GAP DISCOUNT	830 - 840	S9(9)V99	11
82	CMS CALCULATED MANUFACTURER DISCOUNT	841 - 851	S9(9)V99	11
83	APPLICABLE DISCOUNT PERCENTAGE FOR SPECIFIED SMALL MANUFACTURER DRUGS	852 - 853	X(2)	2
84	APPLICABLE DISCOUNT PERCENTAGE FOR SPECIFIED MANUFACTURER DRUGS DISPENSED TO LIS BENEFICIARIES	854 - 855	X(2)	2
85	FILLER	856 - 895	X(40)	40
86	ALTERNATE SERVICE PROVIDER ID QUALIFIER	896 - 897	X(2)	2
87	ALTERNATE SERVICE PROVIDER ID	898 - 912	X(15)	15
88	ORIGINAL SUBMITTING CONTRACT	913 - 917	X(5)	5
89	CORRECTED MEDICARE BENEFICIARY IDENTIFIER	918 - 937	X(20)	20
90	P2P CONTRACT OF RECORD	938 - 942	X(5)	5
91	PBP OF RECORD	943 - 945	X(3)	3
92	ERROR COUNT	946 - 947	9(2)	2
93	ERROR 1	948 - 950	X(3)	3
94	ERROR 2	951 - 953	X(3)	3

95	ERROR 3	954 - 956	X(3)	3
96	ERROR 4	957 - 959	X(3)	3
97	ERROR 5	960 - 962	X(3)	3
98	ERROR 6	963 - 965	X(3)	3
99	ERROR 7	966 - 968	X(3)	3
100	ERROR 8	969 - 971	X(3)	3
101	ERROR 9	972 - 974	X(3)	3
102	ERROR 10	975 - 977	X(3)	3
103	EXCLUSION REASON CODE	978 - 980	X(3)	3
104	FILLER	981 - 1000	X(20)	20

DEFINITION / VALUES
"ACC", "REJ", or "INF"
Must start with 0000001
A number assigned by the plan to identify the prescription drug event. This is an optional field. *non-numeric values should be left justified.
Medicare Health Insurance Claim Number (HICN) or Railroad Retirement Board (RRB) number or Medicare Beneficiary Identifi
Plan identification of the enrollee. Assigned by plan. *non-numeric values should be left justified.
Optional field. If populated, the format is CCYYMMDD.
Valid values are: 1 = M 2 = F
CCYYMMDD
The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans. If populated, the format is CCYYMMDD.
Applies to all PDEs with a DOS >= 01/01/2011. Field is right justified and filled with 5 leading zeros.
Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 29 spaces. Format is MMMMMDDDDPP reject the following billing codes for compounded legend and/or scheduled drugs with a value of: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, or 99999999996.
SPACES
The type of pharmacy provider identifier used in field 14. Valid values are: 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number 99 = Other (**For DOS < 01/01/2025, Reported Gap Discount must = 0; for DOS >= 01/01/2025, Manufacturer Discount must =** Mandatory for standard format. For standard format, valid values are 01 or 07. For non-standard format any of the above values are acceptable.
When Plans report Service Provider ID Qualifier = 99, populate Service Provider ID with the default value PAPERCLAIM defined Facilitation Contract. When Plans report Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report e dashes). * non-numeric values should be left justified.
Valid values are: 0 – 99 If unavailable, use zero.
SPACE
Valid values are: 0 = Not specified 1 = Not a Compound 2 = Compound

Valid values are:
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

Required for Schedule II drugs that are reported as standard, electronically-submitted PDEs with a DOS >= 01/01/2025. This contain the originally prescribed quantity. Must be zero for DOS < 01/01/2025, or for non-Schedule II PDEs.

Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed; quantity in the unit form of the final state of the resulting compound.

SPACES

Valid values are:
0 - 999

The type of prescriber identifier used in field 24.

For PDEs with a DOS >= 01/01/2013, the value of 01 is mandatory for all formats.

For PDEs with a DOS < 01/01/2013, valid values are:
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 for PDEs with a DOS >= 01/01/2012

For PDEs with a DOS < 01/01/2012, optional when the Non-Standard Format Code = B, C, P, or X, but must be a valid value if

Mandatory
* non-numeric values should be left justified.

Coverage status of the drug under Part D and/or the PBP. Valid values are:
C = Covered
E = Supplemental drugs (reported by Enhanced Alternative plans only)
O = Over-the-counter drugs

Valid values are:
A = Adjustment
D = Deletion
SPACE = Original PDE

Format of claims originating in a non-standard format. Valid values are:
A = Medicaid subrogation claim
B = Beneficiary submitted claim
C = COB claim
P = Paper claim from provider
X = X12 837
SPACE = NCPDP electronic format

Valid Values are:
M= Medicare as Secondary
Payer
O = Out-of-network pharmacy (Medicare is Primary)
SPACE = In-network pharmacy (Medicare is Primary)

Plan reported value indicating the Part D Model type applied to the PDE. Valid values are:
01 = Value-based Insurance Design (VBID) Model
07 = Part D Senior Savings (PDSS) Model
SPACES = No Part D Model applied

For PDSS model eligible PDEs submitted by Plans participating in the PDSS Model, this field is required to be populated with 07
a DOS >= 01/01/2022 **and a DOS <= 12/31/2023.**

For VBID model eligible PDEs submitted by Plans participating in a VBID Model, this field is required to be populated with 01 o
DOS >= 01/01/2023. This field is optional for VBID eligible PDEs with a DOS < 01/01/2023.

Applies to covered drugs only.

For non-model PDEs submitted by Plans participating in a Part D Model, and for PDEs submitted by Plans that are not participa
Model, this field must contain SPACES.

Required for PDEs with a DOS >= 01/01/2025 that are included in the Medicare Prescription Payment Plan. Valid values are
Y = PDE is included in the Medicare Prescription Payment Plan
SPACE = PDE is not included in the Medicare Prescription Payment Plan

For DOS < 01/01/2025, this field must contain a SPACE.

SPACES

Optional for PDEs with a DOS >= 01/01/2011. Mandatory on PDEs with a DOS < 01/01/2011. Valid values are:
A = Attachment Point met on this event
C = Above Attachment Point
SPACE = Attachment Point not met

Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.

Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM l
Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administ
Additional Dispensing Fee is reported in Field **38**.

Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will repo
sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.

For PDEs with a DOS >= 01/01/2025, this field contains the estimated amount of remuneration that are not pharmacy price co
the plan sponsor is required to apply, or has elected to apply, to the negotiated price as a reduction in the drug price made av
beneficiary at the point of sale (POS). This estimate includes the rebate or other price concession amount that the plan sponso
receive from a pharmaceutical manufacturer or other non-pharmacy entity and has elected to apply to the negotiated price. T
does not include pharmacy price concessions applied at the point of sale, which must be reported in the “Pharmacy Price Con
POS” field.

For PDEs with a DOS >= 01/01/2024 and a DOS <= 12/31/2024, this estimate must reflect the maximum amount of any contin
or adjustments that the plan sponsor might receive from a network pharmacy that would serve to decrease the total amount
sponsor pays for the drug, i.e., all pharmacy price concessions. This estimate must also reflect the rebate or other price conce
that the plan sponsor expects to receive from a pharmaceutical manufacturer or other non-pharmacy entity and has elected t
negotiated price.

For PDEs with a DOS < 01/01/2024, this field must contain the estimated amount of rebates and/or other price concessions th
sponsor is required to apply, or has elected to apply, to the negotiated price as a reduction in the drug price made available to
beneficiary at the POS.

When there is no rebate or price concession made available to the beneficiary at the POS, this field may be zero dollars. This f
contain a positive dollar amount; the field may never be negative.

For PDEs with a DOS >= 01/01/2025, this field must contain the maximum amount of any contingent payments or adjustment
sponsor might receive from a network pharmacy that would serve to decrease the total amount that the plan sponsor pays fo
all pharmacy price concessions. All other estimated remuneration applied at the POS must be reported in the “Estimated Rem
POS Amount (ERPOSA)” field. This field must contain a positive dollar amount, or zero dollars when there is no price concessio
the POS; the field may never be negative. For PDEs with a DOS < 01/01/2025, this field must be zero.

Amount the plan paid the pharmacy for administering a vaccination. For PDEs with a DOS >= 01/01/2008, a value must be rep
there is a vaccine administration fee or additional Emergency Use Authorization (EUA) dispensing fee charged. For PDEs with a
01/01/2008, this field must be zero. This field may also include amounts of additional dispensing fees paid for EUA oral antivir
procured by the U.S. Government, over and above what was reported in the “Dispensing Fee Paid” field.

SPACES

Reports covered drug cost at or below the out of pocket threshold. Any remaining portion of covered drug cost is reported in
Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine A
Fee or Additional Dispensing Fee.
For PDEs with a DOS < 01/01/2011, when the Catastrophic Coverage Code = SPACE, this field equals the sum of Ingredient Cos
Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee. When
Catastrophic Coverage Code = A, this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Att
Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee falling at or below the OOP threshold. Any remaining por
in GDCA. This amount increments the Total Gross Covered Drug Cost Accumulator amount.

Reports covered drug cost above the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCB
drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administra
Additional Dispensing Fee.
For PDEs with a DOS < 01/01/2011, when the Catastrophic Coverage Code = C, this field equals the sum of Ingredient Cost Paid
Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee above the OOP thr
the Catastrophic Coverage Code = A, this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amoun
Sales Tax + Vaccine Administration Fee or Additional Dispensing Fee falling above the OOP threshold. Any remaining portion i
GDCB. This amount increments the Total Gross Covered Drug Cost Accumulator amount.

Payments made by the beneficiary or by family or friends at point of sale. This amount increments the True Out-of-Pocket (TrO
Accumulator amount.

Other health insurance payments by TrOOP-eligible other payers (e.g., SPAPs). **This field records all third-party payments tha a beneficiary's TrOOP except LICS, Patient Pay Amount, and the Reported Gap Discount (for PDEs with a DOS < 01/01/2025)** increments the True Out-of-Pocket Accumulator amount. For PDEs with a DOS >= 01/01/2023 and DOS <= 12/31/2023, this fie the Inflation Reduction Act Subsidy Amount (IRASA). When this field contains IRASA, the Other TrOOP Amount Indicator field reported with a value of S or B.

Amount the plan advanced at point-of-sale due to a beneficiary's LI status. This amount increments the True Out-of-Pocket A amount.

Amount by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participat

The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid f supplemental drugs, supplemental cost-sharing, and Over-the-Counter drugs are excluded from this field.

The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amou from risk corridor calculations.

Required for PDEs with a DOS >= 01/01/2026. The reported subsidy amount that the plan sponsor advanced at point of sal Drug in the Initial Coverage Period. This field must contain a positive dollar amount, or zero dollars when there is no Selecte applied at the POS; the field may never be negative. On PDEs with a DOS < 01/01/2026, must be zero. This amount will not True Out-of-Pocket Accumulator amount.

Required for PDEs with a DOS >= 01/01/2025. The reported amount that the plan sponsor advanced at point of sale for the M Discount for applicable drugs. On PDEs with a DOS < 01/01/2025, must be zero. This amount will not increment the True Out- Accumulator amount.

The reported amount that the plan sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on P DOS >= 01/01/2011 and a DOS <= 12/31/2024. On PDEs with a DOS < 01/01/2011 or PDEs with a DOS >= 01/01/2025, must be amount increments the True Out-of-Pocket Accumulator amount.

SPACES

Sum of the beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be zero.

SPACES

Sum of the beneficiary's incurred costs for the benefit year known immediately prior to adjudicating the claim. Required on P >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be zero.

SPACES

This code is used for PDEs with a DOS >= 01/01/2023 and a DOS <= 12/31/2023, when the Other TrOOP Amount includes Infla Act Subsidy Amount (IRASA) dollars for benefit year 2023.

Valid values are:
B = indicates the amount reported in Other TrOOP field contains both IRASA and non-IRASA Other TrOOP amounts.
S = indicates the amount reported in Other TrOOP field contains only IRASA Other TrOOP amount.
SPACE = indicates amount reported in Other TrOOP field contains only non-IRASA Other TrOOP amount, if any; and for PDEs w 01/01/2023 or for PDEs with a DOS >= 01/01/2024.

Required on PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024. Plan-defined benefit phase in effect immediately prio
the sponsor began adjudicating the individual claim being reported. Valid values are:
D = Deductible
N = Initial Coverage Period
G = Coverage Gap
C = Catastrophic
For PDEs with a DOS < 01/01/2011, must be SPACE. For PDEs with a DOS >= 01/01/2025, the value of G no longer applies, and
accepted. Applies to covered drugs only.

Required on PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024. Plan-defined benefit phase in effect upon the sponso
adjudication of the individual claim being reported. Valid values are:
D = Deductible
N = Initial Coverage Period
G = Coverage Gap
C = Catastrophic
For PDEs with a DOS < 01/01/2011, must be SPACE. For PDEs with a DOS >= 01/01/2025, the value of G no longer applies, and
accepted. Applies to covered drugs only.

Valid values are:
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Pharmacy
0 = Not Specified
SPACE = Unknown

For PDEs with a DOS >= 01/01/2010, only the values of 1, 2, 3, 4 or 5 are valid for the following scenarios:
1. PDEs that are standard claims (excluding Medicaid Subrogation) and Fill Number = 00
2. PACE claims with non-standard format code not in X, B, P or C and Fill Number = 00

Date sponsor received original claim. Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must
Required for all LI NET PDEs submitted on and after 01/01/2011, regardless of the DOS.

Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with a DOS >= 01/01/2011.
DOS < 01/01/2011, must be SPACES or zero.

Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. Valid values are:
B = Brand
G = Generic
Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be a SPACE. Applies to covered drugs

Formulary tier in which the sponsor adjudicated the claim. Required on PDEs with a DOS >= 01/01/2011.

On PDEs with a DOS >= 01/01/2022, values must be 1-7 or a SPACE.

On PDEs with a DOS >= 01/01/2011 and DOS <= 12/31/2021, values must be 1-6 or a SPACE.

On PDEs with a DOS < 01/01/2011, must be a SPACE.

Applies to covered drugs only.

Indicates if the drug is on the plan's formulary. Valid values are:
F = Formulary
N = Non-Formulary
Required on PDEs with a DOS >= 01/01/2011. On PDEs with a DOS < 01/01/2011, must be a SPACE. Applies to covered drugs

Required on PDEs with a DOS >= 02/28/2013. 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 PDEs with a DOS < 02/28/2013, valid values are SPACES or any of the valid values listed above.

For COB **or Medicaid Subrogation PDEs**, valid values are SPACES or any of the valid values listed above.

Required on PDEs with a DOS >= 02/28/2013. 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/Intellectual Disability
11 = Hospice

For DOS < 02/28/2013, valid values are SPACES or any of the valid values listed above.

For COB or **Medicaid Subrogation PDEs**, valid values are SPACES or any of the valid values listed above.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES
AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill
For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES
AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill
For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES
AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill
For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES
AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill
For PDEs with a DOS < 01/01/2025, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. Used to identify specific types of claims with the following valid values:
SPACES
AA = 340B Claims
AB = Split Billing
AD = Nominal Price
AF = Synchronization Fill
AG = Trial Fill
For PDEs with a DOS < 01/01/2025, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:
SPACES
16 = Long Term Care (LTC) emergency box (kit) or automated dispensing machine
21 = LTC dispensing: 14 days or less not applicable
22 = LTC dispensing: 7 days
23 = LTC dispensing: 4 days
24 = LTC dispensing: 3 days
25 = LTC dispensing: 2 days
26 = LTC dispensing: 1 day
27 = LTC dispensing: 4-3 days
28 = LTC dispensing: 2-2-3 days
29 = LTC dispensing: daily and 3-day weekend
30 = LTC dispensing: Per shift dispensing
31 = LTC dispensing: Per med pass dispensing
32 = LTC dispensing: PRN on demand
33 = LTC dispensing: 7 day or less cycle not otherwise represented
34 = LTC dispensing: 14 days dispensing
35 = LTC dispensing: 8–14 day dispensing method not listed above
36 = LTC dispensing: dispensed outside short cycle, determined to be Medicare Part D after originally submitted to another pa

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACI with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value Patient Residence must be 03.

For PDEs with a DOS >= 02/28/2013 and DOS <= 12/31/2024, if Patient Residence = 03, the valid values are:
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*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACI with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value Patient Residence must be 03.

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29 = LTC dispensing: daily and 3-day weekend
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*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACI with a DOS < 02/28/2013, must be SPACES.

For PDEs with a DOS >= 01/01/2025, any **NCPDP** numeric value or SPACES may be reported in this field; if an LTC-related value Patient Residence must be 03.

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*** Values should be left justified with trailing spaces.**

For PDEs with a DOS >= 02/28/2013 and a DOS <= 12/31/2024, and with a Patient Residence not equal to 03, must be SPACI with a DOS < 02/28/2013, must be SPACES.

Optional on PDEs with a DOS >= 01/01/2025. **Used** for long-term and post-acute care short-cycle (LTPAC) dispensing. Valid va
SPACES
1 = Medication dispensed in a day-supply increment equal to the billed days supply (for example: medication dispensed for a
and billed for a 30-day supply).
2 = 7 days - dispenses medication in 7-day supplies.
3 = 4 days - dispenses medication in 4-day supplies.
4 = 3 days - dispenses medication in 3-day supplies.
5 = 2 days - dispenses medication in 2-day supplies.
6 = 1 day - dispenses medication in 1-day supplies.
7 = 4-3 days - dispenses medication in 4-day, then 3-day supplies.
8 = 2-2-3 days - dispenses medication in 2-day, then 2-day, then 3-day supplies.
9 = Daily and 3-day weekend - dispensed daily during the week and combines multiple days dispensing for weekends.
10 = Per shift dispensing (multiple med passes).
11 = Per med pass dispensing.
12 = PRN on demand.
13 = 7-day or less cycle not otherwise represented.
14 = 14 days dispensing - dispenses medication in 14-day supplies.
15 = 8–14-Day dispensing cycle not otherwise represented.

*** Values should be left justified with trailing spaces.**

For PDEs with a DOS < 01/01/2025, must be SPACES.

For PDEs with a DOS >= 11/13/2016 and a DOS <= 12/31/2024, the type of Adjustment Reason Code used in field 79. Valid val
2 = CMS Audit
3 = CMS Identified Overpayment (CIO)
4 = CGDP Dispute or Appeal
9 = Other
SPACE = Not Applicable

The Adjustment Reason Code Qualifier of 1 has been removed from the list of valid values for PDEs with a DOS >= 11/13/2016
be accepted.

The Adjustment Reason Code Qualifiers of 3, 4, and 9 have been removed from the list of valid values for PDEs with a DOS >=
and will not be accepted.

For PDEs with a DOS >= 11/13/2016 and a DOS <= 12/31/2024, this code will assist CMS to track the reason for an adjustment
Accepted values are dependent upon the adjustment reason code qualifier submitted in field 78. Valid values are:

If the qualifier = 2, the valid value is: OFM, RAC, or MEDIC
If the qualifier = 3, the valid value is: CIO
If the qualifier = 4, the valid value is: DISPUTE or APPEAL
If the qualifier = 9, the valid value is: For future use at CMS' direction
If the qualifier = SPACES, the valid value is: SPACES

* Non-numeric values should be left justified

The Adjustment Reason Code Qualifier of 1 has been removed from the list of valid values for PDEs with a DOS >= 11/13/2016 be accepted.

The Adjustment Reason Codes of CIO, DISPUTE or APPEAL, and For Future use at CMS' direction have been removed from the values for PDEs with a DOS >= 01/01/2025, and will not be accepted.

SPACES

For PDEs with a DOS >= 01/01/2011 and a DOS <= 12/31/2024, the Gap Discount Amount calculated by CMS during on-line PD on data reported in the PDE.

For PDEs with a DOS >= 01/01/2025, the Manufacturer Discount Amount calculated by CMS during on-line PDE editing based reported on the PDE.

For PDEs with a DOS >= 01/01/2025, the phased-in Manufacturer Discount percentage that applies for the benefit year of the specified small manufacturer drugs, as provided by the statute.

For PDEs with a DOS >= 01/01/2025, the phased-in Manufacturer Discount percentage that applies for the benefit year of the specified manufacturer drugs dispensed to Low Income Subsidy (LIS) eligible beneficiaries, as provided by the statute.

SPACES

The Alternate Service Provider ID Qualifier cross-referenced by CMS to the Service Provider ID submitted on the PDE. Valid val
01 = NPI (if the Service Provider ID Qualifier submitted on PDE = 07)
07 = NCPDP Provider ID (if the Service Provider ID Qualifier submitted on PDE = 01)

The Alternate Service Provider ID cross-referenced by CMS to the Service Provider ID submitted on the PDE. Corresponds to th Service Provider ID Qualifier.

Contract that submitted the previously accepted PDE (in conjunction with edit 784).

Populated with Medicare Beneficiary Identifier (MBI) if HICN was received on PDE submission file or the beneficiary MBI has c according to CMS records.

Contract of Record for accepted P2P PDEs

PBP of Record assigned by CMS during P2P Update Process. Returned only when the PBP of Record changes from the time th processed and accepted by CMS.

Count of errors encountered during processing

First error encountered during processing

Second error encountered during processing

Third error encountered during processing
Fourth error encountered during processing
Fifth error encountered during processing
Sixth error encountered during processing
Seventh error encountered during processing
Eighth error encountered during processing
Ninth error encountered during processing
Tenth error encountered during processing
Subcategory reject code for an NDC Error Code of 738 identified in Errors 1-10.
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SUBMITTER ID	4-9	X(6)	6
3	FILE ID	10-19	X(10)	10
4	TLR BHD RECORD TOTAL	20-28	9(9)	9
5	TLR DET RECORD TOTAL	29-37	9(9)	9
6	TLR DET ACCEPTED RECORD TOTAL	38-46	9(9)	9
7	TLR DET INFORMATIONAL RECORD TOTAL	47-55	9(9)	9
8	TLR DET REJECTED RECORD TOTAL	56-64	9(9)	9
9	FILLER	65-1000	X(936)	936

DEFINITION / VALUES
"TLR"
Must match HDR
Must match HDR
Total count of BHD records
Total count of DET records
Total count of ACC records as determined by DDPS processing
Total count of INF records as determined by DDPS processing
Total count of REJ records as determined by DDPS processing
SPACES

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH
1	RECORD ID	1-3	X(3)	3
2	SEQUENCE NO	4-10	9(7)	7
3	CONTRACT NO	11-15	X(5)	5
4	PBP ID	16-18	X(3)	3
5	DET RECORD TOTAL	19-25	9(7)	7
6	DET ACCEPTED RECORD TOTAL	26-32	9(7)	7
7	DET INFORMATIONAL RECORD TOTAL	33-39	9(7)	7
8	DET REJECTED RECORD TOTAL	40-46	9(7)	7
9	FILLER	47-1000	X(954)	954

DEFINITION / VALUES
"BTR"
Must match BHD. Must start with 0000001.
Must match BHD
Must match BHD
Total count of DET records
Total count of ACC records as determined by DDPS processing
Total count of INF records as determined by DDPS processing
Total count of REJ records as determined by DDPS processing
SPACES