

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 identifying the Submitter.
Unique ID assigned by Submitter for file identification (can't repeat for 12 months).
Date of file transmission to PDFS in CCYYMMDD format.
Valid values are: 'PROD' = Production file. 'TS1K' = Test file in the 1000-byte format. 'CT1K' = Certification file in the 1000-byte format.
DDPS file creation date in CCYYMMDD format.
DDPS file creation time in HHMMSS format.
'01V2' = DDPS report identifier.
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'
Starts with '0000001' and increments by 1.
Contract Number from submitted batch.
Plan Benefit Package (PBP) ID from submitted batch.
DDPS file creation date in CCYYMMDD format.
DDPS file creation time in HHMMSS format.
' 01V2' = DDPS report identifier.
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	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	QUANTITY PRESCRIBED	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 (TGCD C) ACCUMULATOR	624–634	S9(9)V99	11
53	FILLER	635–636	X(2)	2
54	TRUE OUT-OF-POCKET (TROOP C) 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- 818	X(73)	73
81	CMS CALCULATED SELECTED DRUG SUBSIDY	819-829	S9(9)V99	11
82	CMS CALCULATED GAP DISCOUNT	830-840	S9(9)V99	11
83	CMS CALCULATED MANUFACTURER DISCOUNT	841-851	S9(9)V99	11
84	APPLICABLE DISCOUNT PERCENTAGE FOR SPECIFIED SMALL MANUFACTURER DRUGS	852-853	X(2)	2
85	APPLICABLE DISCOUNT PERCENTAGE FOR SPECIFIED MANUFACTURER DRUGS DISPENSED TO LIS BENEFICIARIES	854-855	X(2)	2
86	DRUG STATUS INDICATOR	856-856	X(1)	1
87	FILLER	857-895	X(39)	39

88	ALTERNATE SERVICE PROVIDER ID QUALIFIER	896-897	X(2)	2
89	ALTERNATE SERVICE PROVIDER ID	898-912	X(15)	15
90	ORIGINAL SUBMITTING CONTRACT	913-917	X(5)	5
91	CORRECTED MEDICARE BENEFICIARY IDENTIFIER	918-937	X(20)	20
92	P2P CONTRACT OF RECORD	938-942	X(5)	5
93	P2P PBP OF RECORD	943-945	X(3)	3
94	ERROR COUNT	946-947	9(2)	2
95	ERROR 1	948-950	X(3)	3
96	ERROR 2	951-953	X(3)	3
97	ERROR 3	954-956	X(3)	3
98	ERROR 4	957-959	X(3)	3
99	ERROR 5	960-962	X(3)	3
100	ERROR 6	963-965	X(3)	3
101	ERROR 7	966-968	X(3)	3
102	ERROR 8	969-971	X(3)	3
103	ERROR 9	972-974	X(3)	3
104	ERROR 10	975-977	X(3)	3
105	EXCLUSION REASON CODE	978-980	X(3)	3
106	FILLER	981-1000	X(20)	20

DEFINITION / VALUES
Status of PDE after DDPS processing.
Valid values are: 'ACC' = Accepted 'REJ' = Rejected 'INF' = Informational
Starts with '0000001' and increments by 1.
Number assigned by the plan to identify the prescription drug event. Optional field.
Medicare Health Insurance Claim Number (HICN), Railroad Retirement Board (RRB) number or Medicare Beneficiary Identifier (MBI).
Beneficiary identification number assigned by the plan.
Beneficiary date of birth. Optional field.
Valid values are: '1' = Male '2' = Female
Date the prescription was filled.
Date the plan paid the provider for the prescription drug event. Optional field (mandatory for fallback prescription drug plans).
Reference number assigned by the provider to identify the prescription drug event.
11-digit National Drug Code (NDC).
SPACES
Code qualifying the Service Provider ID.
Valid values are: '01' = National Provider Identifier (NPI) '06' = UPIN '07' = NCPDP Provider ID '08' = State License '11' = Federal Tax Number (TIN) '99' = Other
For standard format PDEs (Non-Standard Format Code = <SPACE>), valid values are '01' or '07'. For non-standard format PDEs (Non-Standard Format Code <> <SPACE>), any of the above values are acceptable.
ID assigned to the dispenser.
Code indicating whether the prescription fill is an original or a subsequent fill as it relates to the Prescription Service Reference Number (PSRN).
Valid values are: '00'-'99'
SPACE
Code indicating whether or not the prescription is a compound.
Valid values are: '0' = Not Specified '1' = Not a Compound '2' = Compound

Code indicating product selection determination.

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 or Interchangeable Biosimilar Not in Stock

'5' = Substitution Allowed - Brand Drug or Reference Product Dispensed as Generic or Interchangeable Biosimilar

'6' = Override

'7' = Substitution Not Allowed - Brand Drug or Reference Product Mandated by Law

'8' = Substitution Allowed - Generic Drug or Interchangeable Biosimilar Not Available in Marketplace

'9' = Substitution Allowed By Prescriber but Plan Requests Brand or Reference Product

'A' = Multi-payer Brand/Reference Product Formulary Conflict

Required on PDEs with a DOS $\geq$ 01/01/2025 for Schedule II drugs that are reported as standard, electronically-submitted Standard Format Code = <SPACE>) when Prescription Origin Code = '3' (optional when Prescription Origin Code $\neq$ '3'). This is the quantity prescribed.

For non-Schedule II or non-electronically-submitted PDEs (Non-Standard Format Code $\neq$ <SPACE>), this field must be zero.

For PDEs with a DOS < 01/01/2025, this field must be zero.

Number of Units, Grams, Milliliters, other.

If compounded item, total of all ingredients will be supplied as Quantity Dispensed; report quantity in the unit form of the resulting compound.

SPACES

Estimated number of days the prescription will last.

Valid values are:

'000'-'999'

Code qualifying the Prescriber ID.

Valid values are:

'01' = National Provider Identifier (NPI)

'18' = No Prescriber ID, No Prescription Associated to the transaction (valid for OTC drugs only (Drug Coverage Status Code = '0'))

ID assigned to the prescriber.

When Prescriber ID Qualifier = '18', Prescriber ID must be '0'.

Coverage status of the drug under Part D and/or the PBP.

Valid values are:

'C' = Covered drug

'E' = Supplemental drug (reported by Enhanced Alternative plans only)

'O' = Over-the-counter (OTC) drug

Valid values are:

'A' = Adjustment

'D' = Deletion

<SPACE> = Original

Format of claim origination.

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

Identifies PDEs using pricing rules that differ from the plan's negotiated price.

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 non-model PDEs submitted by plans participating in a Part D Model, and for PDEs submitted by plans that are not part of a Part D 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 PDEs with a DOS < 01/01/2025, this field must contain <SPACE>.

SPACES

Code indicating if the attachment point was met on the PDE.

Optional field.

Valid values are:

'A' = Attachment Point met on this event

'C' = Above Attachment Point

'N' = Attachment Point met; TrOOP subsequently reduced below the OOP threshold due to payment amounts from non-EGWPs reported in PLRO (reported by EGWPs only)

<SPACE> = Attachment Point not met

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

Amount the provider is paid for dispensing the medication. Additional fees may be charged for compounding/mixing multiple medications. Administrative fees are not to be included in this amount.

Amount the provider is paid for sales tax.

For PDEs with a DOS >= 01/01/2025, this field contains the estimated amount of remuneration that are not pharmacy price concessions that the plan is required to apply, or 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 (POS). This estimate includes the rebate or other price concession amount that the plan expects to receive from a pharmaceutical manufacturer or other non-pharmacy entity and has elected to apply to the negotiated price. This estimate must include pharmacy price concessions applied at the POS, which must be reported in the "Pharmacy Price Concessions at 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 concessions or adjustments that the plan might receive from a network pharmacy that would serve to decrease the total amount that the plan pays for the drug (i.e., all pharmacy price concessions). This estimate must also reflect the rebate or other price concession amount that the plan expects to receive from a pharmaceutical manufacturer or other non-pharmacy entity and has elected to apply to the negotiated price.

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

For PDEs with a DOS $\geq$ 01/01/2025, this field must contain the maximum amount of any contingent payments or adjustments that the plan might receive from a network pharmacy that would serve to decrease the total amount that the plan pays for the drug (i.e., price concessions). All other estimated remuneration applied at the POS must be reported in the "Estimated Remuneration (ERPOSA)" field.

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

Amount the provider is paid for administering a vaccination. This field may also include amounts of additional dispensing fee for antiviral drugs 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 the TrOOP Accumulator amount. Drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee + Additional Dispensing Fee.

Reports covered drug cost above the out-of-pocket threshold. Any remaining portion of covered drug cost is reported in the TrOOP Accumulator amount. Drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee + Additional Dispensing Fee.

Payments made by the beneficiary or by family or friends at the POS. This amount increments the TrOOP Accumulator amount. Amount by which patient liability is reduced due to payment by other TrOOP-eligible payers (e.g., third-party payments from Medicare or Medicaid) that is not reported in other TrOOP-eligible fields on the PDE. This amount increments the TrOOP Accumulator amount.

For PDEs with a DOS $\geq$ 01/01/2023 and DOS $\leq$ 12/31/2023, this field may contain the Inflation Reduction Act Subsidy Amount (IRASA). When this field contains IRASA, the Other TrOOP Amount Indicator field must be reported with a value of 'S' or 'B'.

Amount by which patient liability is reduced due to a beneficiary's Low Income Subsidy (LIS) status. This amount increments the TrOOP Accumulator amount.

Amount by which patient liability is reduced due to payment by other non-TrOOP-eligible payers. This amount does not increment the TrOOP Accumulator amount.

Amount of plan payment for a Part D covered drug under the Basic benefit. Amounts paid for supplemental cost-sharing, supplemental Part D drugs and OTC drugs are not to be included in this amount.

Amount of plan payment for enhanced alternative benefits (supplemental cost-sharing and/or non-Part D drugs). For PDEs with a DOS $\geq$ 01/01/2025, Employer Group Waiver Plan (EGWP) Other Health Insurance (OHI) payments are reported in this field.

Required for PDEs with a DOS $\geq$ 01/01/2026. The reported subsidy amount that the plan advanced at the POS for a selected drug during the Initial Coverage Phase. This amount does not increment the TrOOP Accumulator amount.

For PDEs with a DOS $<$ 01/01/2026, must be zero.

Required for PDEs with a DOS $\geq$ 01/01/2025. The reported discount amount that the plan advanced at the POS for the Medicare Part D Discount Program for applicable drugs. This amount does not increment the TrOOP Accumulator amount.

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

Required for PDEs with a DOS $\leq$ 12/31/2024. The reported discount amount that the plan advanced at the POS for the Medicare Part D Discount Program for applicable drugs. This amount increments the TrOOP Accumulator amount.

For PDEs with a DOS $\geq$ 01/01/2025, must be zero.

SPACES

Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudication of the individual claim.

SPACES

Sum of beneficiary's incurred costs for the benefit year known immediately prior to adjudication of the individual claim.

SPACES

Required for PDEs with a DOS $\geq$ 01/01/2023 and a DOS $\leq$ 12/31/2023 when the Other TrOOP Amount field includes Inflation Subsidy Amount (IRASA) dollars for benefit year 2023.

Valid values are:

'B' = Amount reported in the Other TrOOP Amount field contains both IRASA and non-IRASA Other TrOOP amounts

'S' = Amount reported in the Other TrOOP Amount field contains only IRASA Other TrOOP amount

<SPACE> = Amount reported in Other TrOOP Amount field contains only non-IRASA Other TrOOP amount, if any

For PDEs with a DOS $<$ 01/01/2023 or for PDEs with a DOS $>$ 12/31/2023, must be <SPACE>.

Plan-defined benefit phase in effect immediately prior to adjudication of the individual claim being reported.

Valid values are:

'D' = Deductible

'N' = Initial Coverage

'G' = Coverage Gap

'C' = Catastrophic

For PDEs with a DOS $\geq$ 01/01/2025, valid values are 'D', 'N' or 'C'.

Applies to covered drugs only (Drug Coverage Status Code = 'C').

Plan-defined benefit phase in effect upon completing adjudication of the individual claim being reported.

Valid values are:

'D' = Deductible

'N' = Initial Coverage

'G' = Coverage Gap

'C' = Catastrophic

For PDEs with a DOS $\geq$ 01/01/2025, valid values are 'D', 'N' or 'C'.

Applies to covered drugs only (Drug Coverage Status Code = 'C').

Code indicating the origin of the prescription.

Valid values are:

'O' = Not Known

'1' = Written

'2' = Telephone

'3' = Electronic

'4' = Facsimile

'5' = Pharmacy

'6' = No Associated Prescription (valid for OTC drugs only (Drug Coverage Status Code = 'O'))

<SPACE> = Unknown

Date the plan received the original claim.

Date and time the plan began adjudicating the claim in Greenwich Mean Time.

Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug.

Valid values are:

'B' = Brand

'G' = Generic

Applies to covered drugs only (Drug Coverage Status Code = 'C').

Formulary tier in which the plan adjudicated the claim.

Valid values are:

'1'-'7', or <SPACE>.

For PDEs with a DOS < 01/01/2022, valid values are '1'-'6' or <SPACE>.

Applies to covered drugs only (Drug Coverage Status Code = 'C').

Plan reported value indicating whether the drug is on the plan's formulary.

Valid values are:

'F' = Formulary

'N' = Non-Formulary

Applies to covered drugs only (Drug Coverage Status Code = 'C').

Type of service being performed by a pharmacy.

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 COB or Medicaid subrogation PDEs, valid values are <SPACES> or any of the valid values listed above.

Code identifying the patient's place of residence.

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 COB or Medicaid subrogation PDEs, valid values are <SPACES> or any of the valid values listed above.

Code identifying the type of submission.

Optional for PDEs with a DOS >= 01/01/2025.

Valid values are:

'AA' = 340B

'AB' = Split Billing

'AD' = Nominal Price

'AF' = Synchronization Fill - Shortened Days Supply

'AG' = Trial Fill - Shortened Days Supply

<SPACES>

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

Code identifying the type of submission.
Optional for PDEs with a DOS >= 01/01/2025.

Valid values are:

'AA' = 340B
'AB' = Split Billing
'AD' = Nominal Price
'AF' = Synchronization Fill - Shortened Days Supply
'AG' = Trial Fill - Shortened Days Supply
<SPACES>

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

Code identifying the type of submission.
Optional for PDEs with a DOS >= 01/01/2025.

Valid values are:

'AA' = 340B
'AB' = Split Billing
'AD' = Nominal Price
'AF' = Synchronization Fill - Shortened Days Supply
'AG' = Trial Fill - Shortened Days Supply
<SPACES>

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

Code identifying the type of submission.
Optional for PDEs with a DOS >= 01/01/2025.

Valid values are:

'AA' = 340B
'AB' = Split Billing
'AD' = Nominal Price
'AF' = Synchronization Fill - Shortened Days Supply
'AG' = Trial Fill - Shortened Days Supply
<SPACES>

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

Code identifying the type of submission.
Optional for PDEs with a DOS >= 01/01/2025.

Valid values are:

'AA' = 340B
'AB' = Split Billing
'AD' = Nominal Price
'AF' = Synchronization Fill - Shortened Days Supply
'AG' = Trial Fill - Shortened Days Supply
<SPACES>

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 Patient Residence must be '03'.

For PDEs with a DOS <= 12/31/2024, if Patient Residence = '03', valid values are:

'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 pharmacy
<SPACES>

For PDEs with a DOS < 01/01/2025, and with a Patient Residence <> '03', 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 Patient Residence must be '03'.

For PDEs with a DOS <= 12/31/2024, if Patient Residence = '03', valid values are:

'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 pharmacy
<SPACES>

For PDEs with a DOS < 01/01/2025, and with a Patient Residence <> '03', 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 Patient Residence must be '03'.

For PDEs with a DOS <= 12/31/2024, if Patient Residence = '03', valid values are:

'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 pharmacy
<SPACES>

For PDEs with a DOS < 01/01/2025, and with a Patient Residence <> '03', 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 Patient Residence must be '03'.

For PDEs with a DOS <= 12/31/2024, if Patient Residence = '03', valid values are:

'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 pharmacy
<SPACES>

For PDEs with a DOS < 01/01/2025, and with a Patient Residence <> '03', 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 Patient Residence must be '03'.

For PDEs with a DOS <= 12/31/2024, if Patient Residence = '03', valid values are:

'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 pharmacy
<SPACES>

For PDEs with a DOS < 01/01/2025, and with a Patient Residence <> '03', must be <SPACES>.

Used for long-term and post-acute care short-cycle (LTPAC) dispensing.

Optional for PDEs with a DOS >= 01/01/2025.

If Patient Residence = '03', valid values are:

'1' = Medication dispensed in a day-supply increment equal to the billed days supply (for example: medication dispensed for 30 days 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

<SPACES>

For PDEs with a DOS < 01/01/2025, or with a Patient Residence <> '03', must be <SPACES>.

Type of Adjustment Reason Code.

Valid values are:

'2' = CMS Audit

'3' = CMS Identified Overpayment (CIO)

'4' = CGDP Dispute or Appeal

'9' = Other

<SPACE> = Not Applicable

For PDEs with a DOS >= 01/01/2025, valid values are '2' or <SPACE>.

Adjustment Reason Code value for CMS to track the reason for a PDE adjustment or deletion. Accepted values are dependent on the Adjustment Reason Code Qualifier.

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 = <SPACE>, the valid value is: <SPACES>

For PDEs with a DOS >= 01/01/2025, valid values are 'OFM', 'RAC', 'MEDIC' or <SPACES>.

SPACES

For PDEs with a DOS >= 01/01/2026, the Selected Drug Subsidy amount calculated by CMS during on-line PDE editing based on data reported on the PDE.

For PDEs with a DOS < 01/01/2025, the Gap Discount amount calculated by CMS during on-line PDE editing based on data reported on the PDE.

For PDEs with a DOS >= 01/01/2025, the Manufacturer Discount amount calculated by CMS during on-line PDE editing based on data 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 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 specified manufacturer drugs dispensed to Low Income Subsidy (LIS) eligible beneficiaries, as provided by the statute.

For PDEs with a DOS >= 01/01/2025, this field is populated with the corresponding value identifying whether the NDC was applicable drug, non-applicable drug, or selected drug by DDPS at the time of PDE processing for purposes of Manufacturer Discount/selected drug applicability and reinsurance calculations.

Valid values are:

'1' = Applicable

'2' = Non-applicable

'3' = Selected (effective for DOS >= 01/01/2026)

<SPACE> will be returned when Drug Coverage Status Code = 'E' or 'O', and for PDEs with a DOS < 01/01/2025.

SPACES

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

Valid values are:

'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')

Alternate Service Provider ID cross-referenced by CMS to the Service Provider ID submitted on the PDE. Corresponds to the 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 been received according to CMS records.

Contract of Record for accepted P2P PDEs. This field may also be populated during the P2P Phase III process when the Contract of Record has been subsequently updated after PDE processing.

PBP of Record identified during the P2P Phase III process. This field is populated when the PBP or Record has been subsequently updated after PDE processing.

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	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'
Matches BHD. Starts with '0000001' and increments by 1.
Matches BHD.
Matches 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

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'
Matches HDR.
Matches 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