NCPDP Version D.0
E1 Specifications for Medicare Part D
Effective Date: 05/26/2016

Note: If a "Value" contains quotation marks around it, then the value is a literal character that must be included in the transaction. If a "Value" is listed but does not contain quotation marks, then the value is an example.

M= Mandatory | O = Optional | R= Required

vD.0 E1 Request for Medicare Part D

Transaction Header Segment Mandatory Segment			
Field	**Field Name**	**Value**	**Comments**
1Ø1-A1	BIN NUMBER	“011727”	M – Facilitator BIN
1Ø2-A2	VERSION/RELEASE NUMBER	"D0"	M – D.0 Transaction Format
1Ø3-A3	TRANSACTION CODE	"E1"	M – Eligibility Verification
1Ø4-A4	PROCESSOR CONTROL NUMBER	“2222222222”	M – Must be as indicated for E1
1Ø9-A9	TRANSACTION COUNT	"1"	M – One occurrence
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	"Ø1" or “07”	M – NCPDP Provider ID or NPI Number of Requesting Pharmacy
2Ø1-B1	SERVICE PROVIDER ID	1234567890bbbbb	M – Left justified, space filled
4Ø1-D1	DATE OF SERVICE	20060101	M – Must be within 9 months Prior to the current date or within 4 months after the current date
11Ø-AK	SOFTWARE VENDOR / CERTIFICATION ID	bbbbbbbbbb	M - Field must be submitted but is not validated

Patient Segment Required for Proper Matching			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“01”	M – PATIENT SEGMENT
3Ø4-C4	DATE OF BIRTH	19400615	R – Field must be populated
3Ø5-C5	PATIENT GENDER CODE	1	O – 1 = Male, 2 = Female
31Ø-CA	PATIENT FIRST NAME	JOHN	R - Must submit at least first digit of patient first name
311-CB	PATIENT LAST NAME	DOE	R - Must submit complete patient last name
325-CP	PATIENT ZIP/POSTAL ZONE	34567	O – inclusion of the zip code fields increases the chances for a match

Insurance Segment Mandatory Segment			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“Ø4”	M – INSURANCE SEGMENT
3Ø2-C2	CARDHOLDER ID	998877665	M – Must include one of the following: – ID from Medicare Part A card – ID from Medicare Part B card – Full HICN – Full SSN – Railroad Board Number – Last 4 digits of the SSN

vD.0 E1: Accepted Response for Medicare Part D

The Facilitator sends this response when the data provided in the E1 Request enables the Facilitator to find exactly one matching patient who has Part D coverage that is active on the requested Date of Service.

Response Header Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
1Ø2-A2	VERSION/RELEASE NUMBER	"D0"	M – D.0 Transaction Standard
1Ø3-A3	TRANSACTION CODE	"E1"	M – Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	"1"	M – One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	"A"	M – Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	"Ø1" or “07”	M – NCPDP Provider ID or NPI Number of Requesting Pharmacy
2Ø1-B1	SERVICE PROVIDER ID	1234567890bbbbb	M – Contains the same value provided in the Request
4Ø1-D1	DATE OF SERVICE	ccyymmdd	M – i.e., 20060101 Contains the same value provided in the Request

Response Patient Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“20”	M – Response Patient Segment
504-F4	MESSAGE	Structured messaging	See Structure Message information below. This field will contain data elements that will always be present as well as values that will be populated based on the existence of data in the CMS Eligibility File.

Below is an example of how the structured response will be provided in the Messaging Field, 504-F4.

504-F4 Structured Message Detail				
Field Name	**Field ID**	**Data Start**	**Max Bytes/Max Data Length**	**Values**
LICS Level	LISLVL:	8	1	1 digit numeric (e.g. 0, 1, 2, 3,4, 5) blank (none)
Terminator	;	9	1	Semi-colon
LICS Effective Date	LISEFF:	17	8	CCYYMMDD blank (none)
Terminator	;	25	1	Semi-colon
LICS Termination Date	LISTERM:	34	8	CCYYMMDD blank (none)
Terminator	;	42	1	Semi-colon
Plan Type	PLAN:	48	4	MAPD LINT
Terminator	;	52	1	Semi-colon
Examples: Beneficiary with LIS: LISLVL:3;LISEFF:20120701;LISTERM:20120831;PLAN:MAPD; Beneficiary WITHOUT LIS: LISLVL: ;LISEFF: ;LISTERM: ;PLAN:LINT;				

Response Insurance Additional Information Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATIN	"27"	M – Response Insurance Segment
139-UR	MEDICARE PART D COVERAGE CODE	1	R – Indicates the position of Medicare Part D in the billing order
138-UQ	CMS LOW INCOMECOST SHARING (LICS) LEVEL	N	R – Y for Yes or N for No
240-U1	CONTRACT NUMBER	TESTZ	R – Contract Number of Coverage
757-U6	BENEFIT ID	001	R – PBP Number of the coverage
140-US	NEXT MEDICARE PART D EFFECTIVE DATE	ccyymmdd	This field will not be returned if beneficiary does not have a future Part D plan relative to the submitted Date of Service.
141-UT	NEXT MEDICARE PART D TERMINATION DATE	ccyymmdd	This field will not be returned if beneficiary does not have a future Part D plan relative to the submitted Date of Service. If the beneficiary has a future plan and the termination date is blank in the CMS database, this field will not be returned

Response Patient Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“29”	M – Response Patient Segment
310-CA	PATIENT FIRST NAME	JOHN	R – Will contain the first name of the patient the eligibility query matched on in the TrOOP Database
311-CB	PATIENT LAST NAME	DOE	R - Will contain the last name of the patient the eligibility query matched on in the TrOOP Database
304-C4	DATE OF BIRTH	19650615	R - Will contain the Date of Birth of the patient the eligibility query matched on in the TrOOP Database

Response Status Segment Always Returned by Facilitator Mandatory Segment			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“21”	M – Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	"A"	M – Approved

Response Coordination Of Benefits / Other Payers Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“28”	M – Response Patient Segment
355-NT	OTHER PAYER ID COUNT	3	R – Will contain the count of the number of occurrences of Other Payer Information
338-5C	OTHER PAYER COVERAGE TYPE	01	R – Indicates whether Coverage is Primary, secondary, tertiary, etc.
339-6C	OTHER PAYER ID QUALIFIER	“03”	R – Always 03 for BIN
340-7C	OTHER PAYER ID	123456	R – BIN Number for Coverage
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	TESTBENEPD	R – Processor Control Number for Coverage
356-NU	OTHER PAYER CARDHOLDER ID	TEST00001	R – Cardholder Id for Coverage
992-MJ	OTHER PAYER GROUP ID	TEST00001	R – Group Number for Coverage
142-UV	OTHER PAYER PERSON CODE	010	O –Patient Person Code for coverage. Provided if on file
143-UW	OTHER PAYER PATIENT	1	O– Patient Relationship

	RELATIONSHIP CODE		Code for Coverage, Provided if on file
127-UB	OTHER PAYER HELP DESK NUMBER		O – Payer Helpdesk for coverage. Provided if on file
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	20110101	R – Effective Date of Coverage
145-UY	OTHER PAYER BENEFIT TERMINATION DATE	20111231	O – Termination Date of Coverage. Provided if on file
338-5C	OTHER PAYER COVERAGE TYPE	02	R – Indicates whether Coverage is Primary, secondary, tertiary, etc.
339-6C	OTHER PAYER ID QUALIFIER	“03”	R – Always 03 for BIN
340-7C	OTHER PAYER ID	456789	R – BIN Number for Coverage
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	TESTBENEP2	R – Processor Control Number for Coverage
356-NU	OTHER PAYER CARDHOLDER ID	TEST00002	R – Cardholder Id for Coverage
992-MJ	OTHER PAYER GROUP ID	TEST00002	R – Group Number for Coverage
142-UV	OTHER PAYER PESON CODE	010	O –Patient Person Code for Coverage-provided if on file
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE	1	O– Patient Relationship Code for Coverage, Provided if on file
127-UB	OTHER PAYER HELP DESK NUMBER		O – Payer Helpdesk for coverage-provided if on file
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	20110101	R – Effective Date of Coverage
145-UY	OTHER PAYER BENEFIT TERMINATION DATE.	20111231	O – Termination Date of Coverage-provided if on file
338-5C	OTHER PAYER COVERAGE TYPE	03	R – Indicates whether Coverage is Primary, secondary, tertiary, etc.
339-6C	OTHER PAYER ID QUALIFIER	“03”	R – Always 03 for BIN
340-7C	OTHER PAYER ID	789123	R – BIN Number for Coverage
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	TESTBENEP3	R – Processor Control Number for Coverage
356-NU	OTHER PAYER CARDHOLDER ID	TEST00003	R – Cardholder Id for Coverage
992-MJ	OTHER PAYER GROUP ID	TEST00003	R – Group Number for Coverage
142-UV	OTHER PAYER PESON CODE	010	O –Patient Person Code for coverage. Provided if on file
143-UW	OTHER PAYER PATIENT RELATIONSHIP CODE	1	O– Patient Relationship Code for Coverage, Provided if on file

127-UB	OTHER PAYER HELP DESK NUMBER		O – Payer Helpdesk for coverage. Provided if on file
144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	20110101	R – Effective Date of Coverage
145-UY	OTHER PAYER BENEFIT TERMINATION DATE	20111231	O – Termination Date of Coverage. Provided if on file.

vD.0 E1: Rejected Response for Medicare Part D

The Facilitator sends this response when the data provided in the E1 Request does not enable the Facilitator to find one unique patient.

M= Mandatory | O = Optional | R= Required

Response Header Segment Mandatory Segment			
Field	**Field Name**	**Value**	**Comments**
1Ø2-A2	VERSION/RELEASE NUMBER	"D0"	M – D.0 Transaction Standard
1Ø3-A3	TRANSACTION CODE	"E1"	M – Eligibility Verification
1Ø9-A9	TRANSACTION COUNT	"1"	M – One occurrence
5Ø1-F1	HEADER RESPONSE STATUS	"A"	M – Accepted
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	"Ø1" or “07”	M – NCPDP Provider ID or NPI Number of Requesting Pharmacy
2Ø1-B1	SERVICE PROVIDER ID	1234567890bbbbb	M – Contains the same value provided in the Request
4Ø1-D1	DATE OF SERVICE	ccyymmdd	M – i.e., 20110101 Contains the same value provided in the Request

Response Message Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	“20”	M – RESPONSE STATUS SEGMENT
5Ø4-F4	MESSAGE	See below	Structured manner as outlined below.

Response Status Segment Always Returned by Facilitator			
Field	**Field Name**	**Value**	**Comments**
111-AM	SEGMENT IDENTIFICATION	"21"	M – Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	R	M – Rejected
51Ø-FA	REJECT COUNT	1	R
511-FB	REJECT CODE	See "Non-Matched Reject Codes and Messages" section	R – Varies; three different codes depending on reject reason. See "Reject Codes and Messages" topic for details
130-UF	ADDITIONAL MESSAGE INFORMATION COUNT		R– If 526-FQ is returned
132-UH	ADDITIONAL MESSAGE INFORAMATION QUALIFIER		R – If 526-FQ is returned
526-FQ	ADDL MESSAGE INFORMATION		O – Used for overflow from 5Ø4-F4, if needed (need for overflow not expected)
Note: Other optional fields not shown in these segments are not used. Effective 10/01/2011 the CMS Part D pharmacy helpdesk line has been eliminated. The fields 549-7F and 550-8F were returned as indicated in previous payer sheets, however they are no longer returned as reflected in this payer sheet.			

Reject Codes and Messages

Reject Message General Structure

A Reject (Non-Matched) Eligibility Response complies with the following general rules:

- The Reject Code field (511-FB) will contain an appropriate reject code based on the cause of the reject (see table below).

  The Message field (5Ø4-F4) will contain appropriate descriptive rejection information; this will be a free text message that does not contain parsable information (see table below).

- If needed, overflow rejection information can be placed in Additional Message Information (526- FQ). However, such an overflow is highly unlikely.

E1 Reject Conditions and associated Codes and Messages

Reject Conditions and Associated Codes and Messages

The Facilitator system will return the following reject codes and messages for each condition listed:

Condition	Reject Code	Reject Message	Comments
Not all the required information is provided, even if the submitted Cardholder ID information is correct.	“07”	MCARE ELIG;MISSING REQUIRED FIELD	
Full Cardholder ID matches exactly but first 4 characters of Last Name do not match	"62"	MCARE ELIG;PATIENT NOT FOUND: CARDHOLDER ID MATCHED BUT LAST NAME DID NOT	
Patient not found	"52":	MCARE ELIG;NO PATIENT MATCH FOUND	
Patient found but Part D coverage is not active during the submitted Date of Service	“15”	MCARE ELIG;PATIENT FOUND BUT PART D COVERAGE OUTSIDE SUBMITTED DATE OF SERVICE	
OS on the E1 exceeds the allowable “look back or look forward” timeframe	“VD”	DATE OF SERVICE OUT OF RANGE	
Pharmacy not Contracted with Transaction Facilitator	“05”	MCARE ELIG;INVALID NABP	

Rejected Response Message Text Field Examples

Key: b=blank

Example 1: Eligibility Rejected Response resulting from Cardholder ID matching but Name not matching

Reject Code (511-FB) will be "62 "(Patient/Cardholder ID Name Mismatch)

Message (5Ø4-F4)

MCARE ELIG;PATIENT NOT FOUND: CARDHOLDER ID MATCHED BUT LAST NAME DID NOT

Example 2: Eligibility Rejected Response resulting from inability to match the supplied request data to the database

Reject Code (511-FB) will be "52 "(Non-matched Cardholder ID)

Message (5Ø4-F4)

MCARE ELIG;NO PATIENT MATCH FOUND

Example 3: Eligibility Rejected Response resulting from a found patient not having active Part D coverage on the Date of Service submitted but subsequent coverage exists

Reject Code (511-FB) will be "15" (M/I Date of Service)

Message (5Ø4-F4)

MCARE ELIG;PATIENT FOUND BUT PART D COVERAGE OUTSIDE SUBMITTED DATE OF SERVICE

Example 4: Eligibility Rejected Response resulting from a found patient not having active Part D coverage on the Date Of Service submitted and no subsequent coverage exists

Reject Code (511-FB) will be "52" "(Non-matched Cardholder ID)

Message (5Ø4-F4)

MCARE ELIG;NO PATIENT MATCH FOUND