NCPDP Version D.0
E1 Specifications for Medicare Part D
Effective Date: 01/01/2019

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	“01”	M –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 prior to 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: – Full HICN – Full SSN – Last 4 digits of the SSN – RRB – Full MBI

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. The MBI that will be returned is the MBI that is effective as of the receipt date of the E1 transaction. There may be instances where a pharmacy has submitted a MBI that is no longer active for the patient. In that instance the facilitator will crosswalk to the current MBI and will return the current MBI (based on receipt date) in the formatted Message field (504-F4) on the response.

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	“01”	M –NPI Number of Requesting Pharmacy
2Ø1-B1	SERVICE PROVIDER ID	1234567890bbbbb	Pharmacy provided in the Request
4Ø1-D1	DATE OF SERVICE	ccyymmdd	M – i.e., 20060101 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 Message 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	
LICS Effective Date	LISEFF:	17	8	CCYYMMDD blank (none)
Terminator	;	25	1	
LICS Termination Date	LISTERM:	34	8	CCYYMMDD blank (none)
Terminator	;	42	1	
Plan Type	PLAN:	48	4	MAPD LINT
Terminator	;	52	1	
Active MBI	MBI:	57	11	Patient's Current / Active MBI
Terminator	;	68	1	
Active MBI Effective Date	ED:	72	8	CCYYMMDD blank (none)
Terminator	;	80	1	

Examples:
LISLVL:3;LISEFF:20120701;LISTERM:20120831;PLAN:MAPD;MBI:1AA2BB3CC4A;ED:20170601;
LISLVL: ;LISEFF: ;LISTERM: ;PLAN:LINT;MBI: ;ED: ;
LISLVL:1;LISEFF:20120601;LISTERM: ;PLAN:MAPD;MBI:2CC3BB4RR5D;ED:20170601;

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 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	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	"A"	M – Accepted
	RESPONSE STATUS		
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	“01”	M –NPI Number of Requesting Pharmacy
2Ø1-B1	SERVICE	1234567890bbbbb	Pharmacy
	PROVIDER ID		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 Description	Comments/Message
Service Provider ID Qualifier is not a National Provider Identifier (NPI)	7B	Service Provider ID Qualifier Value Not Supported for Processor/Payer	QUALIFIER MUST BE AN NPI
Not all the required information is provided, even if the submitted Cardholder ID information is correct.	07	M/I Cardholder ID	MCARE ELIG;MISSING REQUIRED FIELD
Full Cardholder ID matches exactly but first 4 characters of Last Name do not match	62	Patient/Card Holder ID Name Mismatch	MCARE ELIG;PATIENT NOT FOUND: CARDHOLDER ID MATCHED BUT LAST NAME DID NOT
Patient not found	52	Non-Matched Cardholder ID	MCARE ELIG;NO PATIENT MATCH FOUND
Patient found but Part D coverage is not active during the submitted Date of Service	15	M/I Date of Service	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	Eligibility Search Time Frame Exceeded	MCARE ELIG;DATE OF SERVICE OUT OF RANGE

Pharmacy not Contracted with Transaction Facilitator	50	Non-matched pharmacy number	MCARE ELIG;SUBMITTER IS NOT CONTRACTED FOR E1
NPI does not appear to be valid	05	M/I Service Provider Number	MCARE ELIG;INVALID NPI
Provider is on the OIG sanction list	559	ID Submitted is associated with a Sanctioned Pharmacy	MCARE ELIG;PROVIDER ON SANCTION LIST
Provider is not active on the NPPES file	877	Service Provider ID Terminated on NPPES File	MCARE ELIG;PROVIDER TERMINATED ON NPPES FILE
Provider is not enrolled with CMS	878	Service Provider ID Not Found On NPPES File	MCARE ELIG;PROVIDER NOT ON NPPES
Pharmacy is on the CMS precluded list	930	ID Submitted Is Associated To A Precluded Pharmacy	MCARE ELIG;PHARMACY IS ON CMS PRECLUDED LIST
NPI is does not have an NPPES taxonomy code = pharmacy	879	Service Provider ID Excluded From Receiving CMS Enrollment Data	MCARE ELIG;NPI IS NOT A PHARMACY
CMS does not allow this provider to receive eligibility data	879	Service Provider ID Excluded From Receiving CMS Enrollment Data	PROVIDER QUESTIONS-CONTACT PARTD_COB@CMS.HHS.GOV

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