NCPDP Pharmacy Reference Guide to the X12/005010X221A1 Health Care Claim Payment/Advice (835)

VERSION 4.2

This paper offers guidance to the pharmacy industry for the use of the X12/05010X221A1 Health Care Claim Payment/Advice (835).

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Version 4.2

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Disclaimer

While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice. If you require legal advice, you should consult with an attorney. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by NCPDP. The listing of an organization does not imply any sort of endorsement and the NCPDP takes no responsibility for the products or tools.

The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by the NCPDP.

The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

This Reference Guide must be used in conjunction with the *X12/005010X221A1 Health Care Claim Payment/Advice (835).* This document does not supersede 05010X221A1. There may be other fields that must be populated that are not noted in this reference guide. This guidance only addresses claims submitted through NCPDP transactions or paper claim forms.

1. PURPOSE

Payers may use this guidance to convey the important features of supporting *X12/05010X221A1 Health Care Claim Payment/Advice (835)* to their business partners. The document should not be used as a standard form to be filled in by payers to provide information that is important to pharmacy providers, pharmacy reconciliation vendors, and other implementation units. Payers may use this reference guide for specific field information as it relates to the NCPDP Telecommunication Standard vD.0.

2. HIGH LEVEL SUMMARY

2.1 TRANSACTION SET LISTING

The X12 Health Care Claim Payment/Advice (835) transaction set is designed for the payment of claims and transfer of remittance information of the Health Care Industry. The objective of Health Care Claim Payment/Advice (835) is to support reimbursement processing for health care products and services.

The 835 transaction is divided into these levels:

- The Header level, Table 1 in Figure 8.1, contains general payment information, such as amount, payee, payer, trace number and payment method[1].
- The Detail level, Table 2 in Figure 8.1, contains the EOB information related to adjudicated claims and services[1].
- The Summary level, Table 3 in Figure 8.1, contains the Provider Level Adjustment (PLB) segment which provides information related to adjustments to the payment amount not specific to Table 2 claims. These adjustments can either increase or decrease the actual payment with respect to the Table 2 claim charges[1].

Figure 8.1 Transaction Set Listing (Figure 8.1 Transaction Set Listing)[1]

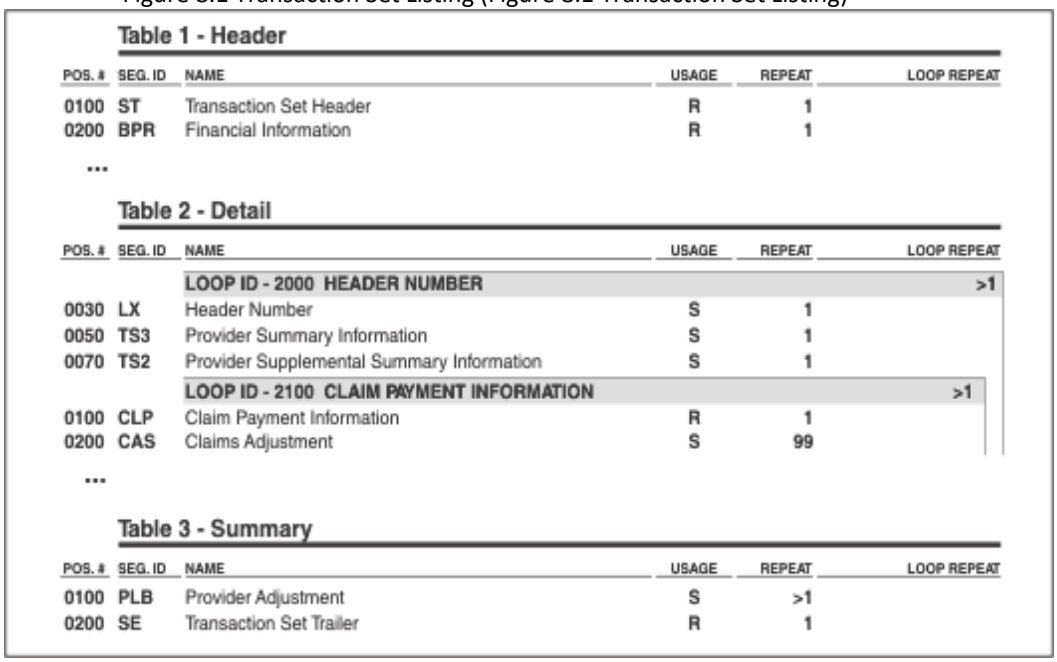

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
0100	ST	Transaction Set Header	R	1	
0200	BPR	Financial Information	R	1	
...					

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000 HEADER NUMBER			>1
0030	LX	Header Number	S	1	
0050	TS3	Provider Summary Information	S	1	
0070	TS2	Provider Supplemental Summary Information	S	1	
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			>1
0100	CLP	Claim Payment Information	R	1	
0200	CAS	Claims Adjustment	S	99	
...					

Table 3 - Summary

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
0100	PLB	Provider Adjustment	S	>1	
0200	SE	Transaction Set Trailer	R	1	

The field usage in the NCPDP Pharmacy Reference Guide reflects the pharmacy industry constraints of 005010X221A1 guidance. In situations where the NCPDP recommended usage gives additional constraints or specific pharmacy usage which is not clearly provided within 005010X221A1, it will be noted in the NCPDP comments column. Whereas required fields within a segment listed are the same as with 005010X221A1, this guide will not report.

[1] Accredited Standards Committee X12, Insurance Subcommittee, X12N. "10.1.2 Data Use by Business Use" Health Care Claim Payment/Advice (835), 005010X221A1. Washington Publishing Company, Apr. 2006. <http://www.wpc-edi.com>. 13

2.2 THE NCPDP 835 RECOMMENDED TRANSACTION SET

Header:

Pos. No.	ID	Seg. Name		Usage	Repeat	Loop Repeat	Notes and Comments
0100	ST	Transaction Set Header		R	1		
0200	BPR	Financial Information	R	1			
0400	TRN	Re-association Trace Number	R	1			
0600	REF	Receiver Identification		S	1		
0700	DTM	Production Date		S	1		
	LOOP ID - 1000A-Payer Identification					1	
0800	N1	Payer Identification		R	1		
1000	N3	Payer Address		R	1		
1100	N4	Payer City, State, Zip Code		R	1		
1200	REF	Additional Payer Identification	S	1			
1300	PER	Payer Business Contact Information		S	1		
1300	PER	Payer Technical Contact Information		R	>1		
1300	PER	Payer WEB Site		S	1		
	LOOP ID - 1000B-Payee Identification					1	
800	N1	Payee Identification	R	1			
1000	N3	Payee Address		S	1		
1100	N4	Payee City, State, Zip Code		S	1		
1200	REF	Additional Payee Identification	S	>1			

Detail:

Pos. No.	ID	Seg. Name		Usage	Repeat	Loop Repeat	Notes and Comments
	00						
0030	LX	Header Number		S	1		
0050	TS3	Provider Summary Information	S	1			
	LOOP ID – 2100-Claim Payment Information					>1	
0100	CLP	Claim Payment Information		R	1		
0300	NM1	Patient Name		R	1		
0300	NM1	Insured Name		S	1		
0300	NM1	Corrected Patient/Insured Name	S	1			
0300	NM1	Service Provider Name		S	1		
0300	NM1	Crossover Carrier Name		S	1		
0300	NM1	Corrected Priority Payer Name	S	1			
0300	NM1	Other Subscriber Name		S	1		
0400	REF	Other Claim Related Information	S	5			
0400	REF	Rendering Provider Information	S	10			
0500	DTM	Coverage Expiration Date		S	1		
0600	DTM	Claim Received Date	S	1			
	LOOP ID – 2110-Service Payment Information					999	
0700	SVC	Service Payment Information		S	1		
0800	DTM	Service Date		S	3		
0900	CAS	Service Adjustment		S	99		
1000	REF	Line Item Control Number		S	1		
1100	AMT	Service Supplemental Amount	S	9			
1300	LQ	Health Care Remark Codes		S	99		

Summary:

Pos. No.	ID	Seg. Name		Usage	Repeat	Loop Repeat	Notes and Comments
010	PLB	Provider Adjustment	S	>1			
0200	SE	Transaction Set Trailer		R	1		

2.3 SEGMENTS WITH SAME USAGE AS 005010X221A1

Segments within the 835 which NCPDP recommends following the same usage as 005010X221A1:

Segment ID	Loop ID	Segment Name
ISA		Interchange Control Header
GS		Function Group Header
ST		Transaction Set Header
TRN		Re-association Trace Number
REF		Receiver Identification
DTM		Production Date
N1	1000A	Payer Identification
N3	1000A	Payer Address
N4	1000A	Payer City, State, Zip Code
PER	1000A	Payer Business Contact Information
PER	1000A	Payer Technical Contact Information
PER	1000A	Payer WEB Site
N1	1000B	Payee Identification
N3	1000B	Payee Address
N4	1000B	Payee City, State, ZIP Code
REF	1000B	Additional Payee Identification
LX	2000	Header Number
NM1	2100	Insured Name
NM1	2100	Corrected Patient/Insured Name
NM1	2100	Crossover Carrier Name
NM1	2100	Corrected Priority Payer Name
NM1	2100	Other Subscriber Name
REF	2100	Rendering Provider Information
DTM	2100	Claim Received Date
REF	2110	Line Item Control Number
PLB		Provider Adjustment
SE		Transaction Set Trailer
GE		Function Group Trailer
IEA		Interchange Control Trailer

2.4 SEGMENTS NOT INCLUDED IN GUIDE

Segments within the 835 which are not included in this reference guide and are not recommended or required for pharmacy use:

Segment ID	Loop ID	Segment Name
CUR		Foreign Currency Information
REF		Version Identification
RDM	1000B	Remittance Delivery Method
TS2	2000	Provider Supplemental Summary Information Corrected
CAS	2100	Claim Adjustment
MIA	2100	Inpatient Adjudication Information
MOA	2100	Outpatient Adjudication Information
PER	2100	Claim Contact Information
DTM	2100	Statement From or To Date
AMT	2100	Claim Supplemental Information
QTY	2100	Claim Supplemental Information Quantity
REF	2110	Service Identification
REF	2110	Rendering Provider Information
REF	2110	HealthCare Policy Identification
QTY	2110	Service Supplemental Quantity

Note: Any segment/data element allowed by 005010X221A1 may be included.

3 835 BALANCING

Refer to Section 1.10.2.1 in 005010X221A1 for balancing guidance.

4 BALANCE FORWARD PROCESSING

The total payment amount in BPR02 cannot be negative. However, when refunds from reversals and corrections exceed the payment for new claims and results in a net negative payment, utilize PLB03-1 with a code of FB (Forwarding Balance) to adjust the BPR02 to zero. The dollar amount in the PLB04 will be the same as the current negative balance in the BPR02. Once the adjustment is made in the PLB04, applying the formula will result in a BPR02 value of zero. When a balance forward adjustment was reported in a previous 835, a subsequent 835 must use the PLB03-1 (Code FB) to add that money back in order to complete the process. The PLB04 will then contain the same dollar amount as the previous 835 but as a positive value. The positive value reduces the payment in the most current 835.

Example 1: Pharmacy scenario:
Total $100 two claims at $50 each from Pharmacy1 (P1)
One reversal $-150 from the same pharmacy
Forward Balance $-50

BPR*I*0*C*CHK**********20090723~
TRN*1*PRN-1*122222222~
CLP*RX1*1*75*50**13*P1-clm1-cyc1~
CLP*RX2*1*75*50**13*P1-clm2-cyc1~
CLP*RX3*22*-180*-150**13*P1-clm3-cyc1~
PLB*1111111111*20091231*FB:PRN-1*-50.~

When a balance forward adjustment was reported in a previous 835, a subsequent 835 must use the PLB03-1 (Code FB forwarding balance) to add that money back in order to complete the process. The PLB04 will then contain the same dollar amount as the previous 835 but as a positive value. The positive value reduces the payment in the most current 835.

5 EFT AND 835 LAG TIME

Providers have encountered difficulties posting payment information when the funds are received and there is a significant delay in receiving the corresponding 835 transaction.

To avoid delays in applying the data, this rule requires the payer to send the 835 no later than three business days after the corresponding EFT CCD + Effective Entry Date or paper check is sent (when the payment amount is greater than zero). The 835 may be sent ahead of the corresponding EFT or check being issued. This minimal gap in time will result in a smaller time lag overall, and the provider will be able to simplify their processes and reduce costs.

This rule applies unless a federal or state regulation already exists.

6 MATCHING PAYMENT DOLLARS TO REMITTANCE DATA (835)

Refer to section 1.10 in 005010X221A1 for guidance on payment dollars and remittance data.

7 SEGMENT AND FIELD REQUIREMENTS

A data element corresponds to a data field in data processing terminology. A data segment corresponds to a record in data processing terminology.[2]

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple element or composite data structure in that segment[3] .

Financial Information – BPR – This segment is required.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
BPR01		Transaction Handling Code	H, I,	R	For Pharmacy, only the following code values may be used: H=Notification Only (use when BPR02 is zero), I=Remittance Information Only (Use when BPR02 is greater than zero)	
BPR03		Credit/ Debit Flag Code	C	R	For Pharmacy, only the following code value may be used: C = Credit	

Additional Payer Identification – REF – This segment is situational but required when the 835 is not being created by the payer (i.e., the payer or third party administrator sends the necessary data to a clearinghouse who creates the 835 and then forwards to the payee).

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
REF01	1000A	Reference Identification	EO	R	EO=Submitter Identification Number	

Provider Summary Information – TS3 – This segment is situational, but pharmacy requires it for reporting of claims summary by provider.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
TS301	2000	Provider Identifier		R		

[2] Accredited Standards Committee X12, Insurance Subcommittee, X12N. "B1.1.2.1 Basic Structure" Health Care Claim Payment/Advice (835), 005010X221A1. Washington Publishing Company, Apr. 2006. <http://www.wpc-edi.com>. B.2

[3] Accredited Standards Committee X12, Insurance Subcommittee, X12N. "B1.1.3.4 Data Segment" Health Care Claim Payment/Advice (835), 005010X221A1. Washington Publishing Company, Apr. 2006. <http://www.wpc-edi.com>. B.11

Claim Payment Information – CLP – This segment is required.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
CLP01	2100	Patient Control Number		R	Prescription/Service Reference Number or when mutually agreed upon the Prescription/Service Reference Number and Fill Number with the characters 'FILL" preceding the Fill Number.	402-D2 Or 402-D2 and 403- D3
CLP02	2100	Claim Status Code		R	**NOTE**: Claim Status Code 4 (deny) may only be returned if the patient is not found and LQ should be returned with NCPDP Reject Code N1 – No Patient Found.	
CLP03	2100	Total Claim Charge		R	Gross Amount Due	430-DU
CLP04	2100	Claim Payment Amount		R	Total Amount Paid	509-F9
CLP05	2100	Patient Responsibility Amount		S	Patient Pay Amount Please Note: This field is not to be used for reversal transactions	505-F5
CLP06	2100	Claim Filing Indicator Code		R	For reporting of Low Income Subsidy Co-Pay Adjustment, the value of ZZ Mutually Defined is used.	

Patient Name – NM1 – This segment is required.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
NM103	2100	Patient Last Name		S	Patient Last Name is required for pharmacy. Report as submitted on the claim.	311-CB
NM104	2100	Patient First Name		S	Patient First Name is required if submitted on the claim.	310-CA
NM108	2100	Identification Code Qualifier	MI	R	For Pharmacy, only the following code value may be used: MI=Member ID	
NM109	2100	Patient Identifier		R	Cardholder ID or when mutually agreed upon the Cardholder ID and the Person Code as submitted on the claim.	302-C2 Or 302-C2 and 303-C3

Service Provider Name – NM1 – This segment is situational but required when the Rendering Provider is different from the Payee.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
NM103	2100	Rendering Provider Last Name or Organization Name		S	If submitting pharmacy is not equal to payee, return name of pharmacy as on file from payer.	

Other Claim Related Identification – REF – This segment is situational.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
REF02	2100	Other Claim Related Identifier		R	One occurrence is required with the REF01=BB, then NCPDP Field 503-F3 (Authorization Number) If REF01=1L, then NCPDP Field 301-C1 (Group ID) If REF01=G1, then NCPDP Field 462-EV (Prior Authorization Number Submitted) If REF01=CE, then enter Network ID (545-2F)	503-F3 301-C1 462-EV 545-2F

Statement From or To Date – DTM –This segment is situational. For Retail Pharmacy claims use the 2110 Loop for Prescription Fill Date. Use 2100 only when 2110 cannot be populated. The Claim Statement Period Start Date (232) should be used to indicate the fill date of the prescription.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
DTM01	2100	Date Time Qualifier	232	R	232=Claim Statement Period Start	
DTM02	2100	Claim Date		R	Date of Service	401-D1

Coverage Expiration Date – DTM – This segment is situational but required when payment is denied because of expiration of coverage and NCPDP Reject Code (511-FB) is equal to 68 or 69. Reject code values available to NCPDP members on the MyNCPDP website in the External Code List.

Service Payment Information – SVC (Note: An Rx is a service) - This segment is situation but required for pharmacy transactions.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
SVC01-1	2110	Product or Service ID Qualifier	N4, HC,	R	N4=NDC HC=HCPCS Code For Multi-Ingredient Compound report as N4	
SVC01-2	2110	Adjudicated Procedure Code		R	Report Product/Service ID without dashes o r for Multi-Ingredient Compounds report a valid identifier without dashes in the Compound Product ID field in the Compound segment.	407-D7 Or 489-TE
SVC02	2110	Line Item Charge Amount		R	NCPDP Gross Amount Due For Multi-Ingredient Compound report amount for the entire compound and not individual ingredients.	430-DU
SVC03	2110	Line Item Provider Payment Amount		R	Total Amount Paid For Multi-Ingredient Compound report amount for the entire compound and not individual ingredients.	509-F9
SVC05	2110	Units of Service Paid Count		S	Quantity Dispensed	442-E7

Service Date – DTM – This segment is situational but required for pharmacy claims.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
DTM01	2110	Date Time Qualifier	472	R	472=Service	
DTM02	2110	Service Date		R	Date of Service	401-D1

Service Adjustment – CAS – This segment is situational. NCPDP recommends that the CAS Segment should be created in 2110 Loop.).

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
CAS01	2110	Claim Adjustment Group Code		R	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	
CAS02*	2110	Claim Adjustment Reason Code		R	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	
CAS05*	2110	Claim Adjustment Reason Code		S	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	
CAS08*	2110	Claim Adjustment Reason Code		S	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	
CAS11*	2110	Claim Adjustment Reason Code		S	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	
CAS14*	2110	Claim Adjustment Reason Code		S	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	
CAS17*	2110	Claim Adjustment Reason Code		S	See the NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document at: https://ncpdp.org/NCPDP/media/pdf/CARC_NCPDPReject.xlsx?ext=.xlsx	

*** A single CAS segment may contain up to six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code(CAS01). The first adjustment is reported in the first adjustment trio (CAS02-04). The second adjustment is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).**

Service Supplemental Information – AMT – This segment is situational but required for pharmacy.

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
AMT01	2110	Amount Code Qualifier	T		For Pharmacy, only the following code values may be used: T - Tax	
AMT02	2110	Service Supplemental Amount		R	If AMT01=T, report tax as the sum of Flat Sales Tax Amount Paid (558-AW) and Percentage Sales Tax Paid (559-AX)	

Health Care Remark Codes – LQ

Field #	Loop ID	Implementation Name	Code	Field R/S	NCPDP Comments	NCPDP Field Reference
LQ01	2110	Code List Qualifier Code	RX	R	RX=NCPDP Reject Code when available	
LQ02	2110	Industry Code		R	Most current NCPDP External Code List (ECL) as found under Standards Lookup Tools at http://www.member.ncpdp.org	

8 APPENDIX A – X12 EXTERNAL 835 FREQUENTLY ASKED QUESTIONS

Additional information can be found concerning 005010X221A1 on the X12 Request for Interpretation Portal: https://x12.org/resources/requests-for-interpretation

9 APPENDIX B. HISTORY OF CHANGES

1. Version 1.0 of the guide was never published
2. December 2010 – Version 1.1 included editorial modifications for typographical errors found in document and the modifications to the TR3 name due to the errata.
3. April 2011 – Version 2 never published
4. April 2011 – Version 3 included modifications made for creation of the 835 Operating Rules for pharmacy. Changes include the following:
    a. Part 1 – added section D – EFT and 835 Lag Time and removed AMT in loop 2100 from the transaction setting list and section E – NCPDP Telecommunication VD.0
    b. Rejections.
    c. Added N3 (Payee Name), N4 (Payee City, State, ZIP Code), NM1 (Insured Patient Name) and MN1 (Corrected Patient/Insured Name) to the "Segments Within the 835 which NCPDP recommends following the same usage as 005010X221A1" table.
    d. Added AMT (Claim Supplemental Information) in the 2100 loop to the "Segments Within the 835 which are not included in the Reference Guide and are not recommended or required for Pharmacy use" table.
    e. Part III – Segment and Field Requirements
        i. Made required and situational statements consistent
        ii. Removed the Payee Address, Payee City, State, ZIP Code, Insured Name, Corrected Patient/Insured Name, Claim Supplemental Amount (in 2100 loop) segments
        iii. Added clarification to BPR01 (Transaction Handling Code) and BPR02 (Credit/Debit Flag)
        iv. Removed reference to Appendix A in TS301 (Provider Identifier)
        v. Added additional mapping and comments to CLP01 (Patient Control Number)
        vi. Added 'Please note:" to CLP05 (Patient Responsibility Amount) comments
        vii. Added additional comments to NM103 (Patient Last Name) and NM104 (Patient First Name)
        viii. Removed NM105 (Patient Middle Name or Initial) and MN107 (Patient Name Suffix) from the Patient Name Segment
        ix. Added additional mapping and comments to NM109 (Patient Identifier)
        x. Removed NM104 (Rendering Provider First Name), NM105 (Rendering Provider Middle Name or Initial) and NM107 (Rendering Provider Name Suffix)
        xi. Added additional mapping and modified the comments in REF01 (Other Claim Related Identification)
        xii. Added additional mapping and modified comments in SVC01-2 (Adjudicated Procedure Code)
        xiii. Removed SVC04 (National Uniform Billing Committee Revenue Code)
        xiv. Added AMT01 (Amount Code Qualifier) and added comments for allowed values
        xv. Modified comments in AMT02 (Service Supplemental Amount)
        xvi. Added CAS and LQ segments into Part III
        xvii. Removed CAS and LQ segments from "Segments Within the 835 which are not included in the Reference Guide and are not recommended or required for Pharmacy use" table.
        xviii. Removed citation appendix and made citations footnotes.
        xix. Modified situation on Health Care Remark Codes.
    f. Removed Appendix C
5. March 2012 – Corrected name of SVC03 to Line Item Provider Payment Amount and added DISA copyright for 2012.
    a. August 2012 - Removed DTM Segment in the 2100 Loop from the table of NCPDP 835 Recommended Transaction Set
    b. Added DTM in 2100 Loop to Segments Not Included in Guide
    c. Added CLP06 Claim Filling Indicator Code to CLP Segment with note that the value of "ZZ" is to be used to represent Low Income Subsidy Co-Pay Adjustments.
    d. Removed use of the value of "U1" from SVC01-1
    e. Removed segment repeat on the Service Adjustment (CAS) Segment

   f. Removed situation from Health Care Remark Codes Segment
6. August 2013 – Editorial update to Section 5 to align with the ***CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0 June 2012.***
7. March 2017 – Editorial updates to remove slashed zeros (Ø) and replace with zero (0). Also updated the copyright statement as revised 2016, the NCPDP logo, updated NCPDP Resources URL and X12 name change from ASC X12 to X12.
8. October 2022 – Version 4.2 (Republication)
   a. Editorial updates for grammar and formatting fixed throughout
   b. Updated summary sentence on title page from “This paper offers guidance to the pharmacy industry in preparing for the implementation of the X12/05010X221A1 Health Care Claim Payment/Advice (835),” to “This paper offers guidance to the pharmacy industry for the use of the X12/05010X221A1 Health Care Claim Payment/Advice (835)" since the 835 has been in use for some time.
   c. Added the figure numbers to section 2.1 and corrected the name of the PLB segment
   d. Changed “Mapping” to “NCPDP Reference Field” in section 7
   e. Corrected the NCPDP Reject Code field reference number from F11-FB to 511-FB and added a note on where to find the reject code values in section 7
   f. Section 7 Patient Name segment under Patient Identifier: Added “and” in the NCPDP Field Reference column to clarify the grouping of field numbers
   g. Section 7 Service Payment Information segment under Adjudicated Procedure Code: Modified the comment for clarity and added the NCPDP field name for field reference 489-TE in the NCPDP Comments column
   h. Updated link to NCPDP Claim Adjustment Reason Code/NCPDP Reject Code Mapping document
   i. Updated Appendix A to be specific to X12 FAQs and provided a link to the X12 Request for Interpretation portal