April 3, 2026

Ms. Joylynn Fix, Chair and Ms. Jolie Matthews
Pharmacy Benefit Management (D) Working Group
National Association of Insurance Commissioners
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Re: Comments on PBM Exam Standards DRAFT dated March 12, 2026

Dear Ms. Fix and Ms. Matthews:

The undersigned companies appreciate the opportunity to comment on the March 12, 2026 revised PBM Exam Standards Draft (the "draft standards") and the NAIC's willingness to work with us on refining the draft standards to be clear and consistent while remaining grounded in applicable state authority. As we have noted in the past, we support the creation of PBM exam standards and believe our suggested revisions will ultimately promote a more workable examination process for regulators and PBMs alike.

After reviewing the revised draft standards, our Coalition respectfully submits the following two priority recommendations intended to support efficient, predictable examinations and to promote consistent application across jurisdictions:

1. Clarify examination scope up front: Direct examiners to define the examination's scope consistent with applicable state law and jurisdictional authority and communicate that scope (including in-scope contracts and operations) to the examined entity at the outset, with the opportunity for response.
2. Right-size document production expectations: Update the document-production standards to focus requests on material, in-scope information; encourage statistically valid sampling where appropriate; and reduce the risk of unintended consequences and unnecessary administrative burden.

Below, we offer additional comments on these issues.

1. Clarify examination scope up front

While we appreciate that the examination standards themselves rightly reference applicable state statutes, rules, and regulations, the scope of the PBM contracts and data that are subject to examination has been broadened to potentially include any contract with an insurer or employer plan, regardless of who bears the risk (e.g., PBM Pricing Methodologies Standard 3). The scope has, further, been expanded to potentially include any line of business, including Medicare and Medicaid (e.g., Pharmacy Claims Standard 1).

Because market conduct examinations are intended to ensure compliance with a state's laws, establishing the scope at the onset is critical. This was raised in several interested parties' written and oral comments to the Working Group, including the importance of working through these issues up front.

- ✓ **Recommended solution**: Update the reference to the NAIC White Paper to instruct examiners to also be familiar with the NAIC's *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* and *Guidance Document – ERISA Preemption and State PBM Laws* (once finalized and adopted). Add a reference to Chapter 16, Scheduling, Coordinating and Communicating, which details scope considerations, to the Scheduling, Coordination and Planning Scope section.

  Further, update the Procedural Considerations by adding language such as "When determining the scope of the examination, examiners should clearly outline which PBM contracts and which lines of business are subject to the state's insurance regulatory oversight and included in the examination. Examiners should consult applicable state law, federal law, and legal rulings relevant to federal preemption and provide the PBM the opportunity to raise concerns relevant to the scope as part of the preliminary examination information and in advance of the estimated commencement of the examination."

  Additionally, remove references to requesting Medicare data, which is preempted by federal law, and update references to Medicaid data to state the information is out of scope unless specifically subject to the state insurance regulator's oversight.

2. Right-size document production expectations

We understand from prior discussions that the intent of the draft standards is to provide the foundation for PBM examinations, which each state will adapt based on their priorities and laws. However, the document, as written, consistently requires all correspondence, all contracts, all amendments, all versions of materials, and all claims. This removes examiner discretion and conflicts with the NIAC Market Regulation Handbook's (Handbook) long-standing reliance on official correspondence, final documentation, sampling, and relevance.

While PBMs are distinct from health insurance issuers in that they are not risk-bearing entities, the approach to examination should be consistent across all regulated entities. The Handbook itself is designed with this in mind – general chapters that detail processes and standards that apply universally and specific chapters that outline examination standards for specific entities or lines of business.

We ask the drafting group to update the standards' document production requirements as detailed below.

a. Correspondence

The draft standards require production of all correspondence, including all emails, call notes, and informal communications, and redlined copies of documents. This represents a significant departure from established examination norms and standards across other lines of insurance and other regulated entities.[1]

[1] The current Handbook has narrow instances in which correspondence is required (e.g., Chapter 24, Conducting the Health Examination's credentialing process standards require correspondence to providers relating to the credentialing process). There are also limited instances where notes are expected (e.g., underwriter's notes on a system log in Chapter 26, Conducting the Long-Term Care Examination). Finally, email references are limited to broad communications (e.g., Chapter 27, Conducting the Consumer Credit Examination's request for saved, stored, or archived email that was

As proposed, this expectation could unintentionally discourage and prevent efficient, informal communications with pharmacies as regulated entities seek to ensure all routine exchanges are captured for examination purposes. For example, if a pharmacy has a question regarding its contract, the standards may hinder the PBM's ability to connect the pharmacy with a live representative for guidance unless the PBM has built a system to record the call or call notes for production during examination.

We are, further, concerned that this would impose significant new burdens and could require new systems for compliance while slowing down analysis of records that are relevant to statutory compliance and increasing the likelihood that key compliance issues are obscured by inconsequential information.

- ✓ **Recommended solution**: Instead of requiring all official and unofficial correspondence, request an explanation or a walkthrough of the contracting and credentialing process used by the PBM that would outline timelines, standard documents and types of communications that are used in the process and require PBMs to provide policies and procedures relating to contracting, template contracts and amendments offered, final executed contracts, and provider manuals (e.g., PBM Pricing and Methodologies: Standard 4, PBM Provider/Pharmacy Relations: Standard 1, PBM Provider/Pharmacy Relations: Standard 2, PBM Pharmacy Network Adequacy: Standard 1, and PBM Pharmacy Audits: Standard 1). The standards should, further, note that additional materials could be requested when specific concerns are identified which indicate a potential violation of state law.

b. Sampling

The current Handbook rightfully treats sampling as a foundational examination methodology.[2] While we appreciate the revised draft standards reference sampling in the Procedural Considerations, the individual draft standards typically require production of "all" relevant materials.

This will slow both PBM production and, in some cases, regulator review without a clear demonstration that such breadth is warranted by a cost-benefit analysis. These expectations are also likely to lead to noncompliance findings and penalties if a regulated entity cannot respond timely or completely to requests, or if response timelines do not appropriately reflect the scope and complexity of the request.

We understand that examiners may find it appropriate to request 100% of a sample size at times; however, they should not be required to do so to align to the NAIC's examination standards. Chapter 17 (Sampling) details variations in sample sizes to reach statistically valid conclusions,

broadcast to the sales force) and complaint handling (e.g., Chapter 24A, Conducting the ACA Related Examination). We have not identified any references in the current Handbook requiring redlined versions of documents.

[2] *See* Standard Fourteen of the Core Competencies in Chapter 5 of the Handbook. There are, further, hundreds of references to sampling and requesting information relevant to the standard being reviewed throughout the Handbook. For example, Chapter 16 (Scheduling, Coordinating, and Communicating) discusses methods examiners will use to select the files for the sample or census review. Chapter 24's (Conducting the Health Examination) provider credentialing techniques instruct examiners to use the company's provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities, for further review and Chapter 24A's (Conducting the ACA Related Examination) grievance procedures require a sample of grievance documents to be reviewed.

cautioning that regulators should carefully weigh the costs and benefits when making sampling decisions, such as whether gains in precision or higher confidence are merited by the cost of producing and investigating a larger sample of files.

- ✓ **Recommended solution**: Align with other chapters by leveraging broader language that permits examiner discretion consistent with core principles, such as "claim files" instead of "all claims data…" (e.g., PBM Pricing and Methodologies: Standard 2, 3, 4, 5; Pharmacy Claims: Standard 1), "pharmacy contracts" rather than "all pharmacy contracts" (e.g., Pharmacy Claims: Standard 1), and "network contracts" rather than "all network contracts" (e.g., Pharmacy Network Adequacy: Standard 2).

  Further, update the Procedural Considerations section to add a reference to Chapter 17, in addition to the current reference to Chapter 20, and language to encourage examiners to leverage rolling production timelines and good faith extensions, particularly for more complex or comprehensive data and document production requests.

c. Request, Receipt and Treatment of Proprietary and Confidential Information

We appreciate the draft standards' reference to Chapter 12 of the Handbook, which addresses confidentiality broadly, and language instructing examiners to take care not to disclose trade secret information and allowing PBMs to mark exhibits or portions of the examination reports as "confidential and proprietary" when state law permits. However, we are concerned that the draft standards do not adequately align with other NAIC-adopted protections for the request, receipt, and treatment of proprietary and trade secret information.

Current NAIC model laws on financial examinations and market conduct surveillance, and core licensing guidelines for PBMs, provide strong protections for regulated entities' competitively sensitive information, including treatment as confidential by law and privileged and protection from state open records laws, subpoena, discovery, or admissibility as evidence in any private civil action.[3] Further, the NAIC market regulation core competencies and financial regulation accreditation standards require departments of insurance to ensure contractors protect confidential information.[4] In addition, the current Handbook permits examiner discretion in request, receipt and treatment of proprietary and confidential information from a regulated entity.[5]

By requiring unredacted documents in all instances, the draft standards appear to limit examiner discretion to tailor document production to what is material to the examination's scope and objectives. PBM agreements, pricing methodologies, network and reimbursement terms, and other commercial and operational information frequently reflect negotiated, client-specific arrangements and trade secrets.

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[3] *See* Section 5F of the NAIC Model Law on Examinations (#390), Section 7 of the NAIC Model Law on Market Conduct Surveillance (#693), and the Enforcement portion of Section 2 (Core Licensing Guidelines for PBMs) in the Pharmacy Benefit Manager (PBM) Licensure and Regulation Guidelines for Regulators, as adopted at the Spring 2026 National Meeting. Model 390 and 693 are referenced in Chapter 12 of the Handbook, which is incorporated by reference in the draft standards.

[4] *See* Standard Six of the Core Competencies in Chapter 5 of the Handbook and Part C: Organizational and Personnel Practices of the Accreditation Program Manual, as amended at the Fall 2025 National Meeting.

[5] We have not identified any references in the current Handbook requiring unredacted copies of documents. Instead, for example, Chapter 8 (Enhancing State Market Analysis) makes note that many underwriting guidelines are considered trade secrets and/or proprietary in nature, stating that regulators must review confidentiality laws before issuing data requests.

A default expectation of broad, unredacted production of relevant materials and data can increase the amount of competitively sensitive information collected and retained in examination files without a commensurate regulatory benefit, while increasing the risk of improper disclosure beyond the examination team (including through contractors/vendors, inadvertent handling errors, or public records processes). Such disclosure could materially harm the PBM and its clients. In addition, unredacted production of individual-level or role-identifying information (for example, Pharmacy and Therapeutics (P&T) Committee member information) may create unnecessary safety and privacy risks where the underlying identity information is not needed to evaluate compliance with state law.

These risks are not borne by PBMs and their clients alone. Over-collection and unclear confidentiality guardrails can also create material risks for state regulators and the markets they oversee. Improper disclosure (or even the perceived risk of disclosure) can undermine confidence in the examination process, delay production of relevant materials, and distort competition in the state's markets.

We believe a more balanced approach would ensure alignment with the NAIC's and state insurance regulators' longstanding commitment to protecting competitively sensitive information that could materially harm a regulated entity, its clients, and market competition if publicly released.

The standards should more clearly reflect the balance that state insurance regulators have long struck: regulator access to relevant information needed to assess compliance with applicable law that protects the trade secrets, proprietary business information, and other nonpublic information of the regulated entity, its clients, customers, and patients. Preserving that balance requires clear direction that examiner requests should be targeted to material, in-scope information and that unredacted production should be required only where necessary to determine compliance with the state law(s) being examined.

- ✓ **Recommended solution**: Align with other chapters by removing references to "unredacted" contracts and formats throughout (found in 43 instances throughout the standards) to reflect a relevance/materiality standard (e.g., "unredacted to the extent necessary to confirm compliance with applicable state law"). Further, add language in the Procedural Considerations to instruct examiners to (1) review and confirm the state's confidentiality protections before requesting highly sensitive information; and (2) when requesting unredacted information, identify (and document) why the unredacted information is necessary and relevant to the examination's scope and objectives and why less sensitive alternatives (e.g., sampling, summaries, targeted provisions, or redacted versions) are insufficient.

  Add language such as the following in the Procedural Considerations section:
  "If the examiner determines that unredacted production of data or documents is necessary, the examiner should document the specific examination objective and explain why the unredacted information is relevant and material to determining compliance with the state law(s) being examined and why reasonable alternatives (e.g., sampling, targeted provisions, or redacted production) are insufficient.

  The examiner must ensure the state's confidentiality laws provide that 'documents, materials or other information, including, but not limited to, all working papers, and copies

thereof, created, produced or obtained by or disclosed to the commissioner, or in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries, or any other person in the course of an examination, or in the course of analysis by the commissioner of the financial condition or market conduct of a company, shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.'

If the state's confidentiality laws do not provide substantially the same protections for market conduct examinations, the examiner must coordinate with the PBM to access highly sensitive data relevant to the examination in a manner that appropriately safeguards the information.

These confidentiality expectations apply not only to the department, but also to any contract examiners and vendors, and reasonable steps must be taken to prevent unauthorized access, reproduction, disclosure, or distribution of confidential information."

* * *

We also recommend the Working Group incorporate the claims data template work completed in 2025 and are attaching as reference our October 2025 comments and draft of that template.

We believe that the above changes would preserve examiner access to essential information while ensuring consistency with state and federal law and the general procedures for market conduct examinations in NAIC model laws and the Handbook. Additionally, our suggested revisions would avoid document-production requirements that are unnecessarily burdensome or difficult to operationalize for both the examinee and the examiner.

We welcome the opportunity to discuss any of these recommendations in more detail and look forward to our continued collaboration.

Sincerely,

Franca D'Agostino
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The Cigna Group

Leanne D. Gassaway
VP State Government Affairs
CVS Health

Christine Cappiello
Sr. Director, State Affairs and NAIC
Elevance Health

Mollie Zito
Deputy General Counsel, Regulatory Affairs
UnitedHealth Group

Attachment

Attachment:
Claims Data Template Recommendations
(October 2, 2025)

October 2, 2025

Ms. Joylynn Fix
Pharmacy Benefit Management (D) Working Group
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444 North Capital Street, NW, Suite 700
Washington, DC 20001-1512
Forwarded via email: Jolie H. Matthews (jmatthews@naic.org)

RE: Submission of PBM Market Conduct Claims Data Template Recommendations

Dear Ms. Fix:

The undersigned Coalition of Pharmacy Benefit Managers (PBMs) and health insurers[1] is committed to assisting the Pharmacy Benefit Management (D) Working Group as it develops robust and transparent standards to enable consistent market regulation by state regulators. During our Coalition call with the drafting group, we discussed the importance of establishing a standard claims data template for regulators to leverage when requesting claims data from PBMs. A common template will streamline the data collection process, improve the comparability of information across states, mitigate the risk of inaccuracies due to interpretations, and facilitate a more effective review of market regulation data.

In the context of Market Conduct Examinations (MCEs), the definition of a "standard" claims data universe or layout must be grounded in how PBMs typically store, use, maintain and report data in the ordinary course of business. This objective is best served by leveraging existing operational data structures or commonly calculated values that align with standard reporting rather than imposing artificial reporting constructs that require logic, transformation, or calculation beyond what is routinely maintained or reported.

After reviewing several templates used in recent examinations, the Tennessee template, based on National Council for Prescription Drug Program (NCPDP) standards, offers a strong starting point for standardizing claims data collection. These standards are currently used throughout the PBM industry for claims processing, data reporting and for other purposes making data retrieval efficient and accurate. Further, it deliberately avoids Personally Identifiable Information (PII) concerns and is easily adaptable across various systems, supporting seamless implementation and integration.

While we support NCPDP standards as the basis of the initial request for claims data, the Coalition notes that due to the variances among state PBM laws, not all data fields in the

[1] The Cigna Group, CVS/Aetna, Elevance, UnitedHealth Group

Tennessee template will be applicable in every state or should be the basis of a 100% claims data set. In the context of the Tennessee template, there are instances where deviations from the template make sense.

State Specific Data Requirements: Some data elements required by the Tennessee template do not apply broadly across all states. Moreover, these data fields do not have a corresponding NCPDP field and thus are not going to be standardized across PBMs. These fields include Low Volume Pharmacy Indicators, Sponsor Administrative Fee, Sponsor Amount and Cost Spread to PBM. The Coalition suggests that these, and other state-specific data elements, not be included in the NAIC template to preserve the integrity of a standard layout. State-specific compliance testing can be effectively addressed through:

- Targeted sampling, as endorsed in the NAIC Market Regulation Handbook; or
- Supplemental requests which allow regulators to explore specific issues without burdening all PBMs with non-standard reporting.

Data Elements Needing Calculation/Logic: Some data elements require additional calculations using business rules that are not uniformly applied and, therefore, are more appropriately and efficiently requested as part of an ad-hoc or sample-size claims request. As examples, these data elements include Accumulated Deductible Amount, Remaining Deductible Amount, Remaining Benefit Amount, Amount Applied to Periodic Deductibles and Amount Exceeding Periodic Benefit Maximum. This information cannot be automated and requires manual processes which will create inefficiencies and inaccuracies if applied broadly across all claims.

For your convenience, attached is a draft template for your consideration. Our recommendation is based on Tennessee's template and modified to allow for variances in state law. The data elements noted above are highlighted in the draft and those elements would therefore be done through either a sample-size methodology or some other type of agreeable process outside of the full claims dataset. We expect that states may have to supplement this template with other NCPDP standards to enforce their specific state laws, but those state-specific elements should not be included in the NAIC adopted template. To keep data operability across the industry, we would recommend that where deviations are necessary, they should be based on NCPDP standards wherever possible.

We appreciate the opportunity to contribute to this important initiative and look forward to working collaboratively with the working group to refine the template.

Sincerely,

Franca D'Agostino
Sr. Director, State Regulatory Affairs
The Cigna Group

Leanne D. Gassaway
VP State Government Affairs
CVS/Aetna

Christine Cappiello
Sr. Director, State Affairs and NAIC
Elevance Health

Mollie Zito
Deputy General Counsel
UnitedHealth Group

List of Pharmacy Claims

File Name: ClaimsWks[week numbers].xlsx. E.g., "ClaimsWks1and2.xlsx, ClaimsWks3and4.xlsx", etc.
Data should be submitted in bi-weekly files to manage file size.

The files should be downloaded from company system(s) and contain one record for each paid claim transaction submitted by pharmacies physically located in Tennessee, mail order pharmacies that served Tennessee residents, or specialty pharmacies that served Tennessee residents that the company processed within the scope of the audit.

Characters are required in all requested fields if applicable to a claim.

PBM may exclude information if the information pertains exclusively to plans in T.C.A. § 56-7-3102(1)(8).)

Table Field	Type	NCPDP Field	Long Field Name	Definition	Notes
503_F3	A	503-F3	Authorization Number	Number assigned by the processor to identify an authorized transaction.	
283	D	283	Original Claim Received Date	The date the pharmacy submitted the claim electronically for a paper claim- matching program.	MM/DD/YYYY
578	D	578	Adjudication Date	Date the claim or adjustment is processed.	MM/DD/YYYY
101_A1	A	101-A1	BIN Number	Card Issuer ID or Bank ID Number used for network routing.	
103_A3	A	103-A3	Transaction Code	Code identifying the type of transaction.	
104_A4	A	104-A4	Processor Control Number	Number assigned by the processor.	
201_B1	A	201-B1	Service Provider ID	NPI	The Service Provider ID should correspond to a NPI found on the Pharmacies Table
PhrmNme	A		Pharmacy Name		
Address1	A		Pharmacy Address Line 1		
Address2	A		Pharmacy Address Line 2 (if necessary)		
City	A		Pharmacy City		
State	A		Pharmacy State Abbreviation		
ZIPCode	A		Pharmacy Zip Code		
LwVolCrt	A		Low-Volume Pharmacy Indicator	Whether the pharmacy certified as a low-volume pharmacy with the PBM pursuant to Rule 0780-01-95-.10 for any portion of the calendar year	"Y"=Low Volume Pharmacy, "N"=Not a Low Volume Pharmacy
401_D1	D	401-D1	Date of Service	Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.	MM/DD/YYYY
332_CY	A	332-CY	Patient ID	ID assigned to the patient.	
302_C2	A	302-C2	Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the plan.	
301_C1	A	301-C1	Group ID	ID assigned to the cardholder group or employer group.	
524_FO	A	524-FO	Plan ID	Assigned by the processor to identify a set of parameters, benefit, or coverage criteria used to adjudicate a claim.	
455_EM	A	455-EM	Prescription/Service Reference Number Qualifier	Indicates the type of billing submitted.	
402_D2	A	402-D2	Prescription/Service Reference Number	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	
436_E1	A	436-E1	Product/Service ID Qualifier	Code qualifying the value in 'Product/Service ID' (407-D7).	
407_D7	A	407-D7	Product/Service ID	ID of the product dispensed or service provided.	
442_E7	N	442-E7	Quanity Dispensed	Quantity dispensed expressed in metric decimal units.	
403_D3	N	403-D3	Fill Number	The code indicating whether the prescription is an original or a refill.	
405_D5	N	405-D5	Days Supply	Estimated number of days the prescription will last.	
406_D6	A	406-D6	Compound Code	Code indicating whether or not the prescription is a compound.	

Table Field	Type	NCPDP Field	Long Field Name	Definition	Notes
408_D8	A	408-D8	Dispense As Written (DAW)/Product Selection Code	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	
414_DE	D	414-DE	Date Prescription Written	Date prescription was written.	MM/DD/YYYY
415_DF	N	415-DF	Number of Refills Authorized	Number of refills authorized by the prescriber.	
460_ET	N	460-ET	Quanity Prescribed	Amount expressed in metric decimal units.	
429_DT	A	429-DT	Unit Dose Indicator/Special Packaging Indicator	Code indicating the type of dispensing dose.	
600_28	A	600-28	Unit Of Measure	NCPDP standard product billing codes.	
461_EU	A	461-EU	Prior Authorization Type Code	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	
462_EV	A	462-EV	Prior Authorization Number Submitted	Number submitted by the provider to identify the prior authorization.	
337_4C	A	337-4C	Coordination of Benefits/Other Payments Count	Count of other payment occurrences.	
338_5C	A	338-5C	Other Payer Coverage Type	Code identifying the type of 'Other Payer ID' (340-7C).	
339_6C	A	339-6C	Other Payer ID Qualifier	Code qualifying the 'Other Payer ID' (340-7C).	
340_7C	A	340-7C	Other Payer ID	ID assigned to the payer.	
443_E8	D	443-E8	Other Payer Date	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	MM/DD/YYYY
341_HB	N	341-HB	Other Payer Amount Paid Count	Count of the payer amount paid occurrences.	
342_HC	A	342-HC	Other Payer Amount Paid Qualifier	Code qualifying the 'Other Payer Amount Paid' (431-DV).	
431_DV	N	431-DV	Other Payer Amount Paid	Amount of any payment known by the pharmacy from other sources.	
409_D9	N	409-D9	Ingredient Cost Submitted	Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due' (430-DU).	
412_DC	N	412-DC	Dispensing Fee Submitted	Dispensing fee submitted by the pharmacy. This amount is included in the 'Gross Amount Due' (430-DU).	
477_BE	N	477-BE	Professional Service Fee Submitted	Amount submitted by the provider for professional services rendered.	
433_DX	N	433-DX	Patient Paid Amount Submitted	Amount the pharmacy received from the patient for the prescription dispensed.	
438_E3	N	438-E3	Incentive Amount Submitted	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due' (430-DU).	
478_H7	N	478-H7	Other Amount Claimed Submitted Count	Count of other amount claimed submitted occurrences.	
479_H8	A	479-H8	Other Amount Claimed Submitted Qualifier	Code identifying the additional incurred cost claimed in 'Other Amount Claimed Submitted' (480-H9).	
480_H9	N	480-H9	Other Amount Claimed Submitted	Amount representing the additional incurred costs for a dispensed prescription or service.	
426_DQ	N	426-DQ	Usual and Customary Charge	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	
430_DU	N	430-DU	Gross Amount Due	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Other Amount Claimed' (480-H9).	
423_DN	A	423-DN	Basis of Cost Determination	Code indicating the method by which 'Ingredient Cost Submitted' (Field 409-D9) was calculated.	

Table Field	Type	NCPDP Field	Long Field Name	Definition	Notes
450_EF	A	450-EF	Compound Dosage Form Description Code	Dosage form of the complete compound mixture.	
451_EG	A	451-EG	Compound Dispensing Unit Form Indicator	NCPDP standard product billing codes.	
452_EH	A	452-EH	Compound Route of Administration	Code for the route of administration of the complete compound mixture.	
447_EC	N	447-EC	Compound Ingredient Component Count	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	
488_RE	A	488-RE	Compound Product ID Qualifier	Code qualifying the type of product dispensed.	
489_TE	A	489-TE	Compound Product ID	Product identification of an ingredient used in a compound.	
448_ED	N	448-ED	Compound Ingredient Quantity	Amount expressed in metric decimal units of the product included in the compound mixture.	
449_EE	N	449-EE	Compound Ingredient Drug Cost	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	
490_UE	A	490-UE	Compound Ingredient Basis of Cost Determination	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	
545_2F	A	545-2F	Network Reimbursement ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.	The Network Reimbursement ID should correspond to a NwkID found on the Network Table
568_J7	A	568-J7	Payer ID Qualifier	Code indicating the type of payer ID.	
569_J8	A	569-J8	Payer ID	ID of the payer.	
505_F5	N	505-F5	Patient Pay Amount	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.	
506_F6	N	506-F6	Ingredient Cost Paid	Drug ingredient cost paid included in the 'Total Amount Paid' (509-F9).	
507_F7	N	507-F7	Dispensing Fee Paid	Dispensing fee paid included in the 'Total Amount Paid' (509-F9).	
521_FL	N	521-FL	Incentive Amount Paid	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the 'Total Amount Paid' (509-F9).	
509_F9	N	509-F9	Total Amount Paid	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (506-F6), 'Dispensing Fee Paid' (507-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4), less 'Patient Pay Amount' (505-F5) and 'Other Payer Amount Recognized' (566-J5).	
693	N	693	Total Gross Amount Due	Total sum of the gross amount due fields on the claim level.	
522_FM	A	522-FM	Basis of Reimbursement Determination	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (506-F6).	
512_FC	N	512-FC	Accumulated Deductible Amount	Amount in dollars met by the patient/family in a deductible plan.	
513_FD	N	513-FD	Remaining Deductible Amount	Amount not met by the patient/family in the deductible plan.	
514_FE	N	514-FE	Remaining Benefit Amount	Amount remaining in a patient/family plan with a periodic maximum benefit.	
517_FH	N	517-FH	Amount Applied to Periodic Deductible	Amount to be collected from a patient that is included in 'Patient Pay Amount' (505-F5) that is applied to a periodic deductible.	

Table Field	Type	NCPDP Field	Long Field Name	Definition	Notes
518_FI	N	518-FI	Amount of Copay	Amount to be collected from the patient that is included in 'Patient Pay Amount' (505-F5) that is due to a per prescription copay.	
520_FK	N	520-FK	Amount Exceeding Periodic Benefit Maximum	Amount to be collected from the patient that is included in 'Patient Pay Amount' (505-F5) that is due to the patient exceeding a periodic benefit maximum.	
346_HH	A	346-HH	Basis of Calculation-Dispensing Fee	Code indicating how the reimbursement amount was calculated for 'Dispensing Fee Paid' (507-F7).	
347_HJ	A	347-HJ	Basis of Calculation-Copay	Code indicating how the Copay reimbursement amount was calculated for 'Patient Pay Amount' (505-F5).	
571_NZ	N	571-NZ	Amount Attributed to Processor Fee	Amount to be collected from the patient that is included in Patient Pay Amount (505-F5) that is due to the processing fee imposed by the processor.	
148_U8	N	148-U8	Ingredient Cost Contracted/Reimbursable Amount	Informational field used when Other Payer-Patient Responsibility Amount (352-NQ) or Patient Pay Amount (505-F5) is used for reimbursement. Amount is equal to contracted or reimbursable amount for product being dispensed.	
149_U9	N	149-U9	Dispensing Fee Contracted/Reimbursable Amount	Informational field used when Other Payer-Patient Responsibility Amount (352-NQ) or Patient Pay Amount (505-F5) is used for reimbursement. Amount is equal to contracted or reimbursable dispensing fee for product being dispensed.	
355_NT	N	355-NT	Other Payer ID Count	Count of other payers with payment responsibility.	
991_MH	A	991-MH	Other Payer Processor Control Number	A number that uniquely identifies the secondary, tertiary, etc. payer to the processor.	
356_NU	A	356-NU	Other Payer Cardholder ID	Cardholder ID for this member that is associated with the Payer noted.	
992_MJ	A	992-MJ	Other Payer Group ID	ID assigned to the cardholder group or employer group by the secondary, tertiary, etc. payer.	
142_UV	A	142-UV	Other Payer Person Code	Code assigned by the other payer to a specific person within a family.	
DrgNmS	A		Drug Name and Strength	Drug Name-The name under which the drug is marketed. I.e., the brand name if applicable or the generic name if the drug was not a brand name drug. Strength-How much of the active ingredient is present in each dosage.	
SpnsrFee	N		Sponsor Administrative Fee	Administrative fee charged to the plan sponsor	
SpnsrAmt	N		Sponsor Amount	Amount charged to the plan sponsor by the PBM for the cost of the drug or device	
SprdCst	N		Cost spread to the PBM	Amount charged to the plan sponsor by the PBM for the cost of the drug or device less the amount paid by the PBM.	