HUMANA®

NCPDP Version 5.1 Request Payer Sheet – Medicare Limited Income Newly Eligible Transition (NET) Program

General Information

Payer Name: Humana	Date: 12/9/09
Plan Name/Group Name: Medicare Limited Income Newly Eligible Transition (NET) Program (Formerly the POS FE Program administered by WellPoint)	
Processor: Argus	Switch: Various (Note: All claims must be routed through RelayHealth)
Effective as of: 01/01/2010	Version/Release #: 1.0
Contact/Information Source: Dedicated Toll-Free number for beneficiaries and pharmacies: 800-783-1307	
Certification Testing Window: Not Applicable	
Provider Relations Help Desk Info: Dedicated Toll-Free number for beneficiaries and pharmacies: 800-783-1307	
Other versions supported: The HIPAA required format is 5.1	

Other Transactions Supported

Transaction Code	Transaction Name
B2	Reversal
B3	Rebill

Medicare Limited Income Newly Eligible Transition (NET) Program

General Processing Notes

All pharmacies with a valid NPI number, regardless of their Network status with Humana, are permitted to submit claims under this Medicare program.

Timely Filing Limits

Timely Filing Limits are the deadlines by which a request for claims payment under this Limited Income NET Program shall be made to the Contractor to qualify for payment. The Timely Filing Limit varies by population, as follows:

- **Beneficiaries who enroll at Point of Sale (POS) (i.e., not already enrolled in a Part D plan)**
  - Beneficiaries who are Full-Benefit Dual Eligibles or SSI-Only Eligibles (and have proof of Low-Income Subsidy (LIS), or "extra help", eligibility in CMS' systems)
    - Request for payment via POS must be made within **36 months of** the Date of Service; however, claims greater than 30 days old will initially be rejected with instruction to contact the LI NET Program at 1-800-783-1307 for an eligibility determination before submitting claim
  - Beneficiaries who are Partial Dual Eligibles or LIS Applicants (and have proof of LIS eligibility in CMS' systems)
    - Request for payment via POS must be made within **30 days of** the date of service (if the beneficiary is Medicare eligible)
  - Beneficiaries who have Medicaid or LIS, but there is no proof in CMS' systems
    - Request for payment must be made within **7 days of** the Date of Service

Once beneficiaries have initially enrolled at the Point of Sale (POS) in the Limited Income NET Program, their eligibility will be validated and they will become an enrollee in the Limited Income NET Part D plan with timely filing limits as shown below. All beneficiaries who are enrolled in the Limited Income NET Part D plan will continue to receive services under this program for up to two (2) months until CMS enrolls them into another Part D plan.

- **Enrollees (those beneficiaries who have been enrolled in LI NET – Medicare Part D Plan ID X0001)**
  - Enrollees may be automatically enrolled by CMS or enrolled via the POS method above
  - Prior authorization is required for claims submitted more than 36 months after the Date of Service, even during period of LI NET enrollment (contact the LI NET Program at 800-783-1307)
  - After disenrollment from the Limited Income NET Program, request for payment must be submitted within **180 days after** the date of disenrollment from the Limited Income NET Program's Unique Contract ID (X0001)

Billing for Enrollees

The Limited Income NET Program is a CMS program operated by Humana under Medicare Part D Contract ID X0001. If the pharmacy provider executes an E1 query and determines that a beneficiary is already enrolled in Contract X0001, it can use the same submission requirements as stated in this Payer Sheet to submit claims for that enrollee. Cardholder ID can be submitted with either:

- the beneficiary's Medicare Health Insurance Claim Number (HICN) or
- the Limited Income NET Cardholder ID as returned on the E1 response.

Pharmacy Providers should be aware that the beneficiary's enrollment in the X0001 Contract ID is for a limited period of time only, and the pharmacy should submit an E1 query each new month to determine when the beneficiary has been enrolled into a different Part D plan.

Paper claims for enrollees in Contract X0001 can be mailed to the following address and should be submitted using the standard National Council for Prescription Drug Programs (NCPDP) Universal Claim Form format.

Medicare Limited Income NET Program
PO BOX 14310
Lexington, KY 40512-4310

Rejection Edits that will be Applied

In addition to existing edits, the following contract-specific edits will be applied to all claims submitted under this Program:

- For beneficiaries whose LIS eligibility cannot be validated at POS, the days' supply will be limited to 34 or the lowest unit dose package allowed (if it exceeds 34 days' supply)
- Therapy Duplication on certain drugs
- Quantity that exceeds Maximum dosage by more than two times the First Data Bank (FDB) guidelines
- Refill Too Soon
- CMS Excluded Drugs
- Claims with a Total Rx Cost greater than $10,000
- Compound Claims with a Total Rx Cost greater than $100
- Non-Network claims with a Usual and Customary that exceeds a reasonable threshold

Pharmacy Providers that believe a claim is valid despite one of these rejection edits should call **1-800-783-1307** to request an override.

Requesting an Eligibility Review

Beneficiaries can request an eligibility review by contacting **1- 800-783-1307** if they had a claim denied at the pharmacy or received a letter indicating that they have been determined to be ineligible for the Limited Income NET Program. A representative from the Limited Income NET Program will review the beneficiary's situation with him/her and conduct an eligibility review to determine if claims should be paid on behalf of the beneficiary. Below you will find examples of proof that the beneficiary can use to verify their Medicaid or LIS eligibility.

- A letter from Medicare or the Social Security Administration (SSA) showing the beneficiary qualifies for "extra help."
    - If the beneficiary automatically qualifies for "extra help," he/she should have received a purple, yellow or green letter from Medicare that can be sent by mail or facsimile to the Limited Income NET Program as proof that he/she qualifies.
    - If the beneficiary applied for, and was awarded, "extra help," he/she can send the "Notice of Award" from SSA by mail or facsimile to the Limited Income NET Program as proof that he/she qualifies.

- Verification received from a CMS caseworker
- A state or county Medicaid staff person can call the Limited Income NET Program on behalf of the beneficiary at 1-800-783-1307 to verify his/her Medicaid status.

- The beneficiary can also send any of the following documents as proof that he/she qualifies for Medicaid. Each item listed below must show that the beneficiary was eligible for Medicaid on the date of service of the claim.
    - A copy of the beneficiary's Medicaid card
    - A copy of a state document that shows the beneficiary has Medicaid
    - A printout from a state electronic enrollment file or screen print from the beneficiary's state Medicaid systems that shows he/she has Medicaid
    - Proof the beneficiary has Medicaid and lives in an institution
    - A bill from an institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month
    - A screen print from the beneficiary's state Medicaid systems showing that he/she lived in an institution for at least a month

Any documentation submitted will be reviewed. Documentation proof can be faxed to Humana at **1-877-210-5592** or mailed to the following address. If documentation shows that the beneficiary qualifies for the Limited Income Net Program, claims will be paid on his/her behalf by Humana's claims processor, Argus.

Medicare Limited Income NET Program
PO BOX 14310
Lexington, KY 40512-4310

Pharmacy help desk hours of operation: 24 hours a day, 7 days a week, 365 days a year
Customer Service hours of operation: Monday-Friday 8 a.m. to 8 p.m. TTY users should call 1-877-801-0369.

Claim Submission Requirements - Billing Transaction

Segments

The following lists the segments available in a Billing Transaction. The document also lists values as defined under Version 5.1. The Transaction Header Segment is mandatory. The Segment Summaries included below list the mandatory data fields. Fields designed as "Mandatory" (M) are in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1 and are the only fields designated mandatory. Fields designated as "Required" (R) must always be sent. Fields designated as "Required When" (RW) will be sent under circumstances that should be explained in the Comment column. **Fields not listed are not applicable to Argus or are not applicable to this particular payer.**

- M = Mandatory (NCPDP mandated)
- R = Required
- RW = Required When

Transaction Header Segment: Mandatory in all cases

Field #	NCPDP Field Name	Value	M/R/RW	Comment
101-A1	BIN Number	610649	M	
102-A2	Version/Release Number	51	M	
103-A3	Transaction Code	B1 = Billing (claim)	M	
104-A4	Processor Control Number	05440000	M	
109-A9	Transaction Count	1	M	Only one transaction allowed for Part D processing.
202-B2	Service Provider ID Qualifier	01 = NPI	M	
201-B1	Service Provider ID		M	
401-D1	Date of Service		M	

110-AK	Software Vendor/Certification ID	blanks	M	

Patient Segment: Required

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	01	M	
331-CX	Patient ID Qualifier	99 = Other	RW	Value 99 required when Patient ID is submitted.
332-CY	Patient ID		RW	Submit Medicaid ID when available. If Medicaid ID is not available, submit SSN if provided. If neither Medicaid ID nor SSN is provided, field is not required.
304-C4	Date Of Birth		R	
305-C5	Patient Gender Code		R	
310-CA	Patient First Name		R	
311-CB	Patient Last Name		R	
322-CM	Patient Street Address		R	
323-CN	Patient City Address		R	
324-CO	Patient State/Provence Address		R	
325-CP	Patient ZIP/Postal Zone		R	
326-CQ	Patient Phone Number		R	

307-C7	Patient Location	RW	Required when patient received claims while in LTC or related type facility which could impact his/her Low-Income Subsidy copay.

Insurance Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	04	M	
302-C2	Cardholder ID		M	Submit Medicare Health Insurance Claim Number (HICN), as it appears on the beneficiary's Medicare card, or the Cardholder ID indicated on a corresponding Eligibility Verification transaction (E1) response
303-C3	Person Code		RW	Suffix should never be submitted.
306-C6	Patient Relationship Code		R	

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	07	M	
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
402-D2	Prescription/Service Reference Number		M	

436-E1	Product/Service ID Qualifier	03 = NDC	M	
407-D7	Product/Service ID		M	
442-E7	Quantity Dispensed		R	
403-D3	Fill Number	00 – 99	R	00 = Original Prescription 01–99 = Refill Prescription
406-D6	Compound Code	2 = Compound	RW	Value 2 is required when billing Multi-Ingredient Compound.
408-D8	DAW/Product Selection Code		R	
414-DE	Date Prescription Written		R	
419-DJ	Prescription Origin Code (POC)	0 = Not Specified 1=Written 2=Telephone 3=Electronic 4=Facsimile	RW	Required on original Rx. When Fill Number is '00' (Original Prescription), the POC requires a value of 1 – 4. Optional on refill Rx. When Fill Number is 01 – 99 (Refill Prescription), the POC may be submitted with values of 0 – 4. Values of 1 – 4 are recommended. Note: POC editing for Original Rx varies by customer. If claim denies, will return NCPDP Reject Code '33' (M/I Prescription Origin Code).

Notes: For **Vaccine Administration** billing, the NDC (436-E1) must be a Part D covered vaccine and the Days Supply (405-D5) must equal 1. Compound claim submission is not allowed for Vaccine Administration billing.

For **Multi-Ingredient Compound** claim submission, in addition to the mandatory and required fields, the following Claim Segment fields are used as specified in the excerpt below.

436-E1	Product/Service ID Qualifier	00 = Not Specified	M	Value 00 is required when billing Multi-Ingredient Compound
407-D7	Product/Service ID		M	Must submit all zeros when billing Multi-Ingredient Compound
442-E7	Quantity Dispensed		R	Must be the quantity of the final compounded product
406-D6	Compound Code	2 = Compound	RW	Value 2 is required when billing Multi-Ingredient Compound
419-DJ	Submission Clarification Code	08 = Process Compound for Approved Ingredients	RW	If 08 is not submitted, claim will deny if any non covered ingredients are submitted

Prescriber Segment: Required

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	03	M	
466-EZ	Prescriber ID Qualifier	01 = NPI 12 = DEA	R	
411-DB	Prescriber ID		R	NPI required; DEA used only if NPI not assigned.

COB/Other Payments Segment: Situational

Note: All non-mandatory fields are marked RW and are required when submitting supplemental claim information.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	05	M	
337-4C	Coordination of Benefits/Other Payments Count		RW	
338-5C	Other Payer Coverage Type		RW	
339-6C	Other Payer ID Qualifier		RW	Required when 34Ø-7C is submitted.
340-7C	Other Payer ID		RW	
443-E8	Other Payer Date		RW	
341-HB	Other Payer Amount Paid Count		RW	
342-HC	Other Payer Amount Paid Qualifier		RW	Required when 431-DV is submitted.
431-DV	Other Payer Amount Paid		RW	
471-5E	Other Payer Reject Count		RW	
472-6E	Other Payer Reject Code		RW	

Additional Information for COB Billing Submissions

When the Primary paid the claim and the claim is being submitted with a COB, Segment with Other Payer Amount to the Secondary Payer.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	05	M	
337-4C	Coordination of Benefits/Other Payments Count		R	
338-5C	Other Payer Coverage Type	01 = Primary	R	
339-6C	Other Payer ID Qualifier		R	
340-7C	Other Payer ID		R	
443-E8	Other Payer Date		R	
341-HB	Other Payer Amount Paid Count		R	
342-HC	Other Payer Amount Paid Qualifier		R	
431-DV	Other Payer Amount Paid		R	

When the Primary rejected the claim and the claim is being submitted with a COB, Segment to the Secondary Payer.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	05	M	
337-4C	Coordination of Benefits/Other Payments Count		R	
338-5C	Other Payer Coverage Type	01 = Primary	R	
339-6C	Other Payer ID Qualifier		R	
340-7C	Other Payer ID		R	
443-E8	Other Payer Date		R	
471-5E	Other Payer Reject Count		R	
472-6E	Other Payer Reject Code		R	

DUR/PPS Segment: Situational

This segment is required when submitting vaccine administration claims for Part D beneficiaries.

Note: All non-mandatory fields are marked RW and are required when submitting vaccine administration billing information.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	08	M	
473-7E	DUR/PPS Code Counter		RW	Must be 1 for vaccine administration billing.
439-E4	Reason for Service Code		RW	
440-E5	Professional Service Code	MA	RW	Must equal MA (Medication Administered) when Incentive Amount Submitted is sent.
441-E6	Result of Service Code		RW	

Additional Information for Vaccine Administration Billing

Vaccine Administration claims may be submitted by all pharmacies, regardless of their Network status. All claims for vaccine administration must meet the following criteria in addition to all existing claim edits: the Product/Service ID (407-D7) must be for a covered Part D vaccine, the Incentive Amount Submitted (438-E3) must be greater than zero and the Professional Service Code (440-E5) of "MA" is required. For Network pharmacies, the pharmacy must also have a contracted administration fee on file with Humana.

Vaccine claims without an Incentive Amount Submitted (438-E3) greater than zero and without a PPS Professional Service Code (440-E5) of "MA" will process as a drug dispensing only claim and will not reimburse an Administrative Fee.

If a claim is submitted for a valid Part D vaccine drug and the incentive amount submitted (438-E3) is greater than zero, but no PPS Professional Service Code (440-E5) of "MA" was submitted, the claim will reject with Reject Code (511-FB) of "E5" and Additional Message Information (526-FQ) of "PROF SVC CODE REQD FOR VACCINE INC FEE."

If a claim is submitted for a valid Part D vaccine drug and the incentive amount submitted is zero or the incentive amount is not submitted, the and PPS Professional Service Code "MA" is submitted, the claim will reject with Reject Code (511-FB) of "E3" and Additional Message Information (526-FQ) of "NON 0 VALUE REQD FOR VACCINE ADMIN."

Pricing Segment: **Mandatory**

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	
409-D9	Ingredient Cost Submitted		R	May be populated with zeros
412-DC	Dispensing Fee Submitted		R	
438-E3	Incentive Fee Submitted		RW	Required when requesting payment for vaccine administration fee.

433-DX	Patient Paid Amount Submitted	R
426-DQ	Usual And Customary Charge	R
430-DU	Gross Amount Due	R

Notes For **Vaccine Administration** claims, the Incentive Amount Submitted (438-E3) must be greater than zero when a PPS Professional Service Code (440-E5) is submitted.

For **Multi-Ingredient Compound** claim billing, the Ingredient Cost Submitted (409-D9) field must contain the sum of the submitted Compound Ingredient Cost (449-EE) fields in the Compound segment.

Compound Segment: Situational

Note: All nonmandatory fields are marked RW and are required when submitting multi-ingredient compound claims using the individual ingredient billing information.

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	10	M	
450-EF	Compound Dosage Form Description Code		RW	Must be the Dosage Form of the complete compound mixture. One occurrence per claim.
451-EG	Compound Dispensing Unit Form Indicator		RW	Must describe the type of unit form applicable for the complete compound mixture. One occurrence per claim.

452-EH	Compound Route of Administration		RW	Must be the code for Route of Administration for the complete compound mixture. One occurrence per claim.
447-EC	Compound Ingredient Component		RW	Count of compound Product IDs (both active and inactive) in the compound mixture. One occurrence per claim, value may be 2 – 25.
488-RE	Compound Product ID Qualifier	03 = NDC	RW	
489-TE	Compound Product ID		RW	Must occur once for each unique ingredient submitted. Can occur up to 25 times per claim.
448-ED	Compound Ingredient Quantity		RW	Must occur once for each unique ingredient submitted. Can occur up to 25 times per claim.
449-EE	Compound Ingredient Drug Cost		RW	Must occur once for each unique ingredient submitted. Can occur up to 25 times per claim.

Other Transaction Information

Reversals

Maximum Number of Transactions Supported per transmission	Max # of transactions supported = 1
What is your reversal window? (If transaction	Time frame = 60 days from initial receipt

is billed today, what is the time frame for reversal to be submitted?)	Customer specific.

NCPDP Version 5.1 Response Payer Sheet – Limited Income Newly Eligible Transition (NET) Program

General Information

Payer Name: Limited Income Newly Eligible Transition (NET) Program	Date: 12/02/2009

Segments

The purpose of this document is to provide further clarity for Pharmacy Providers as to the response data they will receive. This document lists the segments available in a response transaction. The document also lists values as defined under Version 5.1. The Transaction Header Segment is mandatory. The segment summaries included below list the mandatory data fields. See template instructions for mandatory or optional fields and the usage of the M/R/RW and comment columns. Fields designed as "Mandatory" (M) are in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1 and are the only fields designated mandatory. Fields designated as "Required" (R) will always be sent. Fields designated as "Required When" (RW) will be sent under circumstances that should be explained in the Comment column. **Fields not listed are not applicable to Argus or are not applicable to this particular payer. Note that on the Response segments, "Required" should be interpreted as "Reported" by the processor.**

- M = Mandatory (NCPDP mandated)
- R = Required
- RW = Required When

PAID (or Duplicate of Paid) Response

Response Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
102-A2	Version/Release Number	Same value as in request billing	M	51
103-A3	Transaction Code	Same value as in request billing	M	

109-A9	Transaction Count	Same value as in request billing	M	
501-F1	Header Response Status	A	M	A = Accepted
202-B2	Service Provider ID Qualifier	Same value as in request billing	M	
201-B1	Service Provider ID	Same value as in request billing	M	
401-D1	Date of Service	Same value as in request billing	M	

Response Message Segment: Optional

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	20	M	
504-F4	Message		RW	If applicable for Other health insurance reporting and plan-specific messaging

Note: For **Multi-Ingredient Compound** claims, if an ingredient in the compound segment is excluded from coverage, the excluded NDC(s) is returned in the Paid Response Message (504-F4) field.

Response Status Segment: Mandatory

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	
112-AN	Transaction Response Status	P or D	M	P = Paid D = Duplicate of Paid

526-FQ	Additional Message Information	RW	If applicable for Other health insurance reporting and plan-specific messaging

Response Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	22	M	
455-EM	Prescription/Service Reference Number Qualifier	1	M	1 = Rx Billing
4Ø2-D2	Prescription/Service Reference Number		M	

Response Pricing Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	23	M	
5Ø5-F5	Patient Pay Amount		R	May be populated with zeros
5Ø6-F6	Ingredient Cost Paid		RW	Reported back when amount is submitted
5Ø7-F7	Dispensing Fee Paid		RW	Reported back when amount is submitted
521-FL	Incentive Fee Paid		RW	Reported back when amount is submitted
558-AW	Flat Sales Tax Amount Paid		RW	Reported back when amount is submitted
559-AX	Percentage Sales Tax Amount Paid		RW	Reported back when amount is submitted
563-J2	Other Amount Paid Count		RW	Reported when applicable

564-J3	Other Amount Paid Qualifier	RW	Reported when applicable
565-J4	Other Amount Paid	RW	Reported when applicable
566-J5	Other Payer Amount Recognized	RW	Reported when applicable
5Ø9-F9	Total Amount Paid	R	May be populated with zeros
523-FN	Amount Attributed To Sales Tax	RW	Reported when applicable
517-FH	Amount Applied To Periodic Deductible	RW	Reported when applicable
518-FI	Amount Of Copay/Co-Insurance	RW	Reported when applicable
519-FJ	Amount Attributed To Product Selection	RW	Reported when applicable
346-HH	Basis of Calculation-Dispensing Fee	RW	Reported when applicable
347-HJ	Basis of Calculation-Copay	RW	Reported when applicable

Response DUR/PPS Segment: Optional

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	24	M	
567-J6	DUR/PPS Response Code Counter		RW	Required when field 439 and/or 528 is used.
439-E4	Reason For Service Code		RW	Reported when applicable. Can occur up to 9 times.
528-FS	Clinical Significance Code		RW	Reported when applicable.
544-FY	DUR Free Text Message		RW	Reported when applicable.

Reject Response

Response Header Segment: Mandatory

Field #	NCPDP Field Name	Value	M/R/RW	Comment
1Ø2-A2	Version/Release Number	Same value as in request billing	M	51
1Ø3-A3	Transaction Code	Same value as in request billing	M	
1Ø9-A9	Transaction Count	Same value as in request billing	M	
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier	Same value as in request billing	M	
2Ø1-B1	Service Provider ID	Same value as in request billing	M	
4Ø1-D1	Date of Service	Same value as in request billing	M	

Response Message Segment: Optional

Field #	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	20	M	
5Ø4-F4	Message		RW	If applicable for Other health insurance reporting and plan-specific messaging

Response Status Segment: **Mandatory**

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	21	M	
112-AN	Transaction Response Status	R	M	R = Reject
51Ø-FA	Reject Count		R	
511-FB	Reject Code		R	Can occur up to 5 times.
526-FQ	Additional Message Information		RW	If applicable for Other health insurance reporting and plan-specific messaging

Additional Information for Vaccine Administration Claim Response

If a valid Part D vaccine drug and an incentive amount submitted (438-E3) is sent, but PPS Professional Service Code (440-E5) of "MA" was not submitted, the claim will reject with error code E5 and additional message information (526-FQ) of PROF SVC CODE REQD FOR VACCINE INC FEE.

If valid Part D vaccine drug and incentive amount submitted (438-E3) is zero or that field is not submitted and PPS Professional Service Code (440-E5) of "MA" is submitted, the claim will reject with reject code E3 and additional message information (526-FQ) of NON o VALUE REQD FOR VACCINE ADMIN.

Additional Information for Multi-Ingredient Compound Claim Response

If the claim is denied for noncoverage of one or more of the ingredients, the excluded NDC(s) will be reported in the additional message information (526-FQ) field.