EXPRESS SCRIPTS®

F6 Field Change Playbook

This playbook serves as a centralized reference guide for all F6 field changes on claim transactions. Its purpose is to clearly document updates to data fields and help stakeholders understand how these changes may impact reports, tools, integrations, and downstream processes.

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New Fields

The following section summarizes the new fields introduced in F6. For each row, you'll find the field ID, field name, field definition, required status, and example values to help support operational understanding.

Request New Fields

Highlighted fields indicate additional details included in the **Additional Context for Key Changes** section.

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
PATIENT SEGMENT				
618-RR	Patient ID Count	Count of patient ID occurrences	N	
B08-7A	Patient Street Address Line 1	Free-form text for address line 1 information	N	
B09-7B	Patient Street Address Line 2	Free-form text for address line 2 information	N	
A43-1K	Patient Country Code	The country of the patient's permanent residence; not required for US	N	
E06-S8	Species	A basic biological classification containing individuals that resemble one another and may interbreed; not required for humans	N	
PROVIDER SEGMENT				
B96-4A	Provider First Name	First name of the provider (i.e., pharmacist)	N	
B97-4M	Provider Last Name	Last name of the provider (i.e., pharmacist)	N	
CLAIM SEGMENT				
B98-34	Reconciliation ID	A unique identifier assigned by the processor for approved/paid responses that provides a means to identify that transaction should any subsequent transaction or other associated activity occur	Y (reversal transactions only)	
581-XZ	Associated Prescription/Service Reference Number Qualifier	Code qualifying the Associated Prescription/Service Reference Number ID to which the claim/service is related.	N	01 = Rx Billing 02 = Service Billing
D16-KZ	Submission Type Code Count	Count of the Submission Type Code occurrences	N	
D17-K8	Submission Type Code	Code identifying the type of submission as needed for appropriate transaction processing	N	AA = 340B AF = Synchronization Fill
D21-M3	Multiple Prescription/Service Order Group ID	Unique ID assigned by the prescriber or pharmacy system to link multiple product orders together	N	
D22-M4	Multiple Prescription/Service Order Group Reason Code	Indicates the reason for the quantity dispensed and/or days supply as a result of the prescriber issuing grouped prescriptions	N	1 = Injectable Therapy 4 = Unbreakable Package Multiple Locations
D02-KW	Total Prescribed Quantity Remaining	Accumulated Total Prescribed Quantity Remaining as of the date of service.	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
C99-KU	Preparation Environment Type	Code identifying the environment in which the medication was prepared.	N	3 = Negative Pressure Non-sterile/Hazardous
C98-KT	Preparation Environment Event Code	Event which required a special preparation environment.	N	1 = Pill Splitting
582-X0	Associated Prescription/Service Reference Fill Number	Related Fill Number to which the claim/service is associated.	N	
C02-4P	Original Manufacturer Product ID Qualifier	Code qualifying the value in Original Manufacturer Product ID.	N	3 = NDC
C01-4N	Original Manufacturer Product ID	Original ID of the Original Manufacturer/Labeler product that was used to create the repackaged drug being dispensed.	N	
C91-KK	LTPAC Dispense Frequency	Code indicating the frequency of dispensing medication to a LTPAC patient.	N	2 = 7 Days 3 = 4 Days 12 = PRN on Demand
C90-KH	LTPAC Billing Methodology	Code indicating the billing methodology used for the claim.	N	1 = Full quantity dispensed on date of service
C92-KM	Number of LTPAC Dispensing Events	Value indicating the number of times pharmacy dispensed product or service for the claim period requested.	N	
D18-K9	Do Not Dispense Before Date	The earliest date the prescriber indicates a prescribed drug can be dispensed.	N	
PRESCRIBER SEGMENT				
B26-7T	Prescriber Telephone Number Extension	Extension of the telephone number.	N	
B27-7U	Prescriber Street Address Line 1	Free form text for prescriber address line 1 information.	N	
B28-7V	Prescriber Street Address Line 2	Free form text for prescriber address line 2 information.	N	
B42-3C	Prescriber Country Code	Code of the country.	N	
D01-KV	Prescriber DEA Number	ID assigned to a health care provider by the US Drug Enforcement Administration, allowing them to prescribe controlled substances.	N	
D57-RG	Prescriber Place of Service	Code identifying the place where the patient encounter occurred as reported by the prescriber.	N	01 = Pharmacy 11 = Office
COORDINATION OF BENEFITS/OTHER PAYMENTS SEGMENT				

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
C47-9T	Other Payer Adjudicated Program Type	The type of prescription benefit plan/program associated with the Other Payer.	N	1 = Medicaid 2 = Medicare
C49-9V	Other Payer Reconciliation ID	Reconciliation ID as reported by the Other Payer for Paid/Accepted transactions OR for Information Reporting transactions, the designated default value for reporting a previous payer's rejected response as designated in the Other Payer Reject Code value(s) reported in the COB claim.	N	
D51-P7	Other Payer Percentage Tax Exempt Indicator	Code indicating the source of the percentage tax exempt status of the other payer's claim.	N	
D53-P9	Other Payer Regulatory Fee Type Count	Count of Other Payer Regulatory Fee Type Code.	N	
D63-RN	Other Payer Regulatory Fee Type Code	Code identifying the type of Regulatory Fee reported by the other payer.	N	AA = LA RS AB = Other
D52-P8	Other Payer Regulatory Fee Exempt Indicator	Code indicating the source of the regulatory fee exempt status of the other payer's claim.	N	1 = Other Payer/Plan is Tax Exempt
C50-9W	Benefit Stage Indicator Count	Count of Benefit Stage Indicator occurrences.	N	
C51-9X	Benefit Stage Indicator	Code identifying the Benefit Stage(s) which applied to the claim at the time of adjudication.	N	01 = Medicare Part D Deductible
WORKERS' COMPENSATION SEGMENT				
B15-8D	Employer Street Address Line 1	Free-form text for address line1 information.	N	
B16-7G	Employer Street Address Line 2	Free-form text for address line 2 information.	N	
B35-1V	Employer Country Code	Code of the country.	N	
B19-7K	Employer Telephone Number Extension	Extension of the telephone number.	N	
B17-7H	Employer Contact First Name	First name of the employer's primary contact.	N	
B18-7J	Employer Contact Last Name	Last name of the employer's primary contact.	N	
B24-7R	Pay To Street Address Line 1	Free-form text for address line1 information.	N	
B25-7S	Pay To Street Address Line 2	Free-form text for address line 2 information.	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
B39-1Z	Pay To Country Code	Code of the country.	N	
PRICING SEGMENT				
D60-RK	Regulatory Fee Count	Count of Regulatory Fee Type Code.	N	
D61-RL	Regulatory Fee Type Code	Code identifying the type of regulatory fee.	N	AA = LA RS AB = Other
COMPOUND SEGMENT				
C60-AG	Compound Level of Complexity	Value used by the pharmacy to indicate the complexity involved in the preparation of the compounded prescription.	N	See additional detail section
FACILITY SEGMENT				
B95-3Z	Facility ID Qualifier	Code qualifying the Facility ID.	N	Blank = Not specified 1 = Facility Type 2 NPI
B20-7M	Facility Street Address Line 1	Free-form text for address line1 information.	N	
B21-7N	Facility Street Address Line 2	Free-form text for address line 2 information.	N	
B37-1X	Facility Country Code	Code of the country	N	
N TRANSACTION PAYER IDENTIFICATION SEGMENT (NEW) Applicable only for Information Reporting (N) transactions. This segment identifies the payer for which the N is being generated.				
C52-9Y	N Payer IIN	IIN number of the payer for which the N is being generated.	N	
C53-9Z	N Payer Processor Control Number	The Processor Control Number (if used) of the payer which the N is being generated.	N	
C54-AA	N Payer Cardholder ID	Cardholder number for the beneficiary of the payer for which the N is being generated.	N	
C55-AB	N Payer Group ID	The Group ID of the secondary, tertiary, etc. payer for the payer which the N is being generated.	N	
C48-9U	N Payer Adjudicated Program Type	The type of prescription benefit plan/program under which the claim was adjudicated.	N	3 = Commercial 16 = Medicare Part B
C56-AC	N Transaction Source Type	Method in which record of payment was transmitted from the N payer to receiver.	N	
C57-AD	N Transaction Reconciliation ID	The Reconciliation ID (B98-34) returned by the supplemental payer for which the N is being generated.	N	
880-K5	Transaction Reference Number	A reference number assigned by the provider to each of the data records in the batch or real-time transactions. The	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
		purpose of this number is to facilitate the process of matching the transaction response to the transaction. The transaction reference number assigned should be returned in the response.		

Response New Fields

Highlighted fields indicate additional details included in the **Additional Context for Key Changes** section.

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
RESPONSE INSURANCE SEGMENT				
C96-KR	Payer/Health Plan ID Count	Count of Payer/Health Plan ID Occurrences.	N	
RESPONSE PATIENT SEGMENT				
618-RR	Patient ID Count	Count of patient ID occurrences	N	
331-CX	Patient ID Qualifier	Code qualifying the Patient ID.	N	
332-CY	Patient ID	ID assigned to the patient	N	
RESPONSE STATUS SEGMENT				
C72-BH	Help Desk Support Type Count	The number of Help Desk Contact Support Types.	Y	
C71-BG	Help Desk Support Type	The intended entity responsible for contacting the help desk.	Y	See additional details section
C67-BB	Help Desk Business Unit Type Count	The number of Help Desk Business Unit Types.	Y	
C66-BA	Help Desk Business Unit Type	The type of help desk support that is available.	Y	See additional details section
C70-BF	Help Desk Contact Information Qualifier	Code qualifying the value in the Help Desk Contact Information.	Y	See additional details section
C68-BC	Help Desk Contact Information	Value of the specific help desk contact information (e.g.: Telephone Number, Fax Number, URL).	Y	
C69-BD	Help Desk Contact Information Extension	Extension of the help desk contact information.	N	
B98-34	Reconciliation ID	A unique identifier assigned to paid response transactions, provides a means to identify that transaction should any subsequent transaction or other associated activity occur.	Y	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
A28-ZR	Adjudicated Program Type	The type of prescription benefit plan/program under which the claim was adjudicated.	Y	3 = Commercial 5 = Self Pay: Discount Program
RESPONSE CLAIM SEGMENT				
E89-ZO	Formulary Alternative Effective Date	The future date the Formulary Alternative returned in Formulary Alternative ID and/or Formulary Alternative Description will be covered as part of the member's plan formulary.	N	
D42-PV	Formulary Alternative Plan Benefit Tier	Patient cost share tier applied to the formulary alternative product.	N	
D43-PZ	Formulary Alternative Reason Code	Reason for formulary alternative option(s).	N	1 = Step Therapy Required 4 = Preferred Product
D44-P0	Formulary Alternative Required Therapy Indicator Count	Count of Formulary Alternative Required Therapy Indicator Occurrences.	N	
D45-P1	Formulary Alternative Required Therapy Indicator	Code identifying required treatment with specified formulary alternative.	N	1 = Required Treatment; not otherwise specified
D46-P2	Formulary Alternative Required Therapy Time Period Qualifier	Code qualifying Formulary Alternative Required Therapy Time Period Duration.	N	1 = Days 2 = Calendar Month
D47-P3	Formulary Alternative Required Therapy Time Period Duration	Minimum amount of time period duration for required therapy.	N	
D48-P4	Formulary Alternative Required Therapy Time Period Start Date	Start date for the required therapy time period range.	N	
D49-P5	Formulary Alternative Required Therapy Time Period End Date	End date for the required therapy time period range.	N	
931-F8	Maximum Age Qualifier	Code qualifying the maximum age.	N	M = Months
932-GA	Maximum Age	Maximum age at which the product/service is covered (inclusive).	N	
943-GQ	Minimum Age Qualifier	Code qualifying the Minimum Age.	N	D = Days
944-GR	Minimum Age	Minimum age at which the drug is covered (inclusive).	N	
D20-M2	Minimum Amount Qualifier	Qualifies the amount in the Minimum Amount field.	N	MFL = Minimum Fills
D19-M1	Minimum Amount	Minimum amount for a quantity limit as specified in the Minimum Amount Qualifier.	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
934-GC	Maximum Amount Qualifier	Qualifies the amount in the Maximum Amount.	N	DL = Dollar Amount
933-GB	Maximum Amount	Maximum amount for a quantity limit as specified in the Maximum Amount Qualifier.	N	
935-GF	Maximum Amount Time Period	Type of time period associated with the overall Maximum Amount Qualifier.	N	
937-GH	Maximum Amount Time Period End Date	Ending date of Specific Date Range.	N	
936-GG	Maximum Amount Time Period Start Date	Starting date of Specific Date Range.	N	
938-GJ	Maximum Amount Time Period Units	Number of units associated with the overall Maximum Amount Time Period.	N	
D25-M7	Remaining Amount Qualifier	The specific plan benefit amount type represented in the Remaining Amount.	N	RFL = Remaining Fills
D24-M6	Remaining Amount	Remaining amount to a maximum quantity limit based on amounts accumulated, as specified in the Remaining Amount Qualifier.	N	
C59-AF	Benefit Type Opportunity Count	Count of Benefit Type Opportunity that follow.	N	
C58-AE	Benefit Type Opportunity	The type of additional benefit the patient is eligible for.	N	1 = Flu Vaccine Benefit
RESPONSE PRICING SEGMENT				
C94-KP	Patient Pay Component Count	Count of Patient Pay Component Qualifier(s) AND Patient Pay Component Amount(s) occurrences.	Y	
C95-KQ	Patient Pay Component Qualifier	Code qualifying the Patient Pay Component Amount.	Y	See additional details section
C93-KN	Patient Pay Component Amount	The cost share amount attributed to the component of Patient Pay Amount.	Y	
D60-RK	Regulatory Fee Count	Count of Regulatory Fee Type Code.	N	
D61-RL	Regulatory Fee Type Code	Code identifying the type of regulatory fee.	N	AA: LA RS
D62-RM	Regulatory Fee Exempt Indicator	Code indicating the source of the regulatory fee exempt status of the claim.	N	1 = Other Payer/Plan is Tax Exempt
C50-9W	Benefit Stage Indicator Count	Count of Benefit Stage Indicator occurrences.	N	
C51-9X	Benefit Stage Indicator	Code identifying the Benefit Stage(s) which applied to the claim at the time of adjudication.	N	See additional details section
D65-RS	Patient Regulatory Fee Amount	Patient regulatory fee amount obligation or portion thereof when	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
		benefit is set up to directly pass regulatory fee onto the patient.		
RESPONSE DUR/PPS SEGMENT				
475-J9	DUR/DUE Co-Agent ID Qualifier	Code qualifying the value in DUR/DUE Co-Agent ID.	N	03 = National Drug Code (NDC)
476-H6	DUR/DUE Co-Agent ID	Identifies the co-existing agent contributing to the DUR/DUE event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	N	
E93-ZC	DUR/DUE Co-Agent Description	Description of the co-existing agent contributing to the DUR/DUE event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	N	
E95-Z9	Other Pharmacy ID Qualifier	Code qualifying the value in 'Other Pharmacy ID'.	N	01 = National Provider ID (NPI)
E96-Z8	Other Pharmacy ID	ID assigned to the pharmacy associated to the prescription or previous event contributing to the DUR/DUE conflict.	N	
E97-Z7	Other Pharmacy Name	Name of the pharmacy associated to the prescription or previous event contributing to the DUR/DUE conflict.	N	
E98-Z6	Other Pharmacy Telephone	Telephone number of the pharmacy associated to the prescription or previous event contributing to the DUR/DUE conflict.	N	
E94-ZA	Unit Of Measure For Previous Dispensed Quantity	Code indicating the Unit of Measure associated to the 'Quantity of Previous Dispensed'.	N	EA = Each
F01-Z4	Other Prescriber ID Qualifier	Code qualifying the value in 'Other Prescriber ID'.	N	01 = National Provider ID (NPI)
F02-Z3	Other Prescriber ID	ID assigned to the prescriber associated to the prescription or previous event contributing to the DUR/DUE conflict.	N	
E99-Z5	Other Prescriber Last Name	Last name of the prescriber associated to the prescription or previous event contributing to the DUR/DUE conflict.	N	
F03-Z2	Other Prescriber Telephone Number	The 10-digit telephone number of the prescriber of the prescription causing the DUR/DUE conflict.	N	
F05-Z0	DUR/DUE Compound Product ID Qualifier	Code qualifying the value in 'DUR/DUE Compound Product ID'.	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
F04-Z1	DUR/DUE Compound Product ID	Identifies the specific compound ingredient within the submitted compound claim, contributing to the DUR/DUE event.	N	
F06-YO	DUR/DUE Maximum Daily Dose Quantity	Maximum quantity associated to the DUR/DUE daily dose limitation.	N	
F07-YL	DUR/DUE Maximum Daily Dose Unit of Measure	Code indicating the Unit of Measure associated to the 'DUR/DUE Maximum Daily Dose Quantity'.	N	
F08-YJ	DUR/DUE Minimum Daily Dose Quantity	Minimum quantity associated to the DUR/DUE daily dose limitation.	N	
F09-YI	DUR/DUE Minimum Daily Dose Unit of Measure	Code indicating the Unit of Measure associated to the 'DUR/DUE Minimum Daily Dose Quantity'.	N	
RESPONSE PRIOR AUTHORIZATION SEGMENT				
498-PT	Prior Authorization Expiration Date	Date the prior authorization ends.	N	
RESPONSE OTHER PAYERS SEGMENT				
D41-PQ	Other Payer Relationship Type	Identifies the relationship of the other payer information returned by the reporting payer or entity for coordination with the Other Payer Coverage Type value for that payer.	Y	CC = Change in Coverage RP = Responding Payer
D50-P6	Other Payer Benefit Classification	Identifies the benefit classification for other payer information associated to the patient.	Y	RX = Prescription Benefit
C47-9T	Other Payer Adjudicated Program Type	The type of prescription benefit plan/program associated with the Other Payer.	Y	3 = Commercial
B23-7Q	Other Payer Help Desk Telephone Number Extension	Extension of the telephone number.	N	
D23-M5	Other Payer Name	Name of the other payer.	N	
RESPONSE OTHER RELATED BENEFIT DETAIL SEGMENT (NEW) Information can be returned in the following fields when the Date of Service (401-D1) is in an active period for ESRD, Hospice, Institutional, Disability, or LIS or when other benefit information is available.				
C97-KS	Plan Type	The Medicare Plan specific to its beneficiary or benefit.	N	PDP = Medicare Prescription Drug Plan
C88-KF	LIS Level	Low income co-pay category.	N	
C87-KD	LIS Effective Date	The effective date of the Low Income Subsidy benefit for the date of service requested.	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
C89-KG	LIS Termination Date	The termination date of the Low Income Subsidy benefit for the date of service requested.	N	
C61-AH	Disability Effective Date	The effective date of the disability benefit for the date of service requested.	N	
C63-A5	ESRD Indicator	End Stage Renal Disease benefit indicator flag.	N	1 = End-stage Renal Disease
C62-AJ	ESRD Effective Date	The effective date of the ESRD benefit for the date of service requested.	N	
C64-A6	ESRD Termination Date	The termination date of the ESRD benefit for the date of service requested.	N	
C76-G4	Hospice Effective Date	The effective date of the hospice benefit for the date of service requested.	N	
C79-G7	Hospice Termination Date	The termination date of the Hospice benefit for the date of service requested.	N	
C78-G6	Hospice Provider Number	The Facility NPI (National Provider Identifier) of the Hospice Provider.	N	
C77-G5	Hospice Facility Name	Name identifying the hospice where the service was rendered.	N	
C65-A8	Hospice Telephone Number	Phone number of the hospice.	N	
C73-BJ	Institutional Indicator	Code indicating the institutional service.	N	
C74-BK	Institutional Effective Date	The effective date of the institutional benefit for the date of service requested.	N	
C75-GD	Institutional Termination Date	The termination date of the institutional benefit for the date of service requested.	N	
D26-M8	Other Benefit Count	Count of Other Benefit Type Code occurrences.	N	
D40-PN	Other Benefit Type Code	The type of other benefit for the date of service requested.	N	1 = Dialysis
D34-MZ	Other Benefit Effective Date	The effective date of the benefit for the date of service requested.	N	
D39-NN	Other Benefit Termination Date	The termination date of the benefit for the date of service requested.	N	
729-TA	State/Province Address	The State/Province Code of the address.	N	
D38-N9	Other Benefit Type ID	The ID for the entity providing the benefit.	N	

Field ID	Field Name	Definitions	Required: Y/N	Sample Values (if applicable)
D35-N1	Other Benefit Facility Name	Name identifying the other benefit facility where the service was rendered.	N	
D36-N7	Other Benefit Facility Telephone Number	Phone number of the Other Benefit Facility.	N	
D37-N8	Other Benefit Detail Information Count	Count of Other Benefit Detail Information Indicator occurrences.	N	
D32-MS	Other Benefit Detail Information Qualifier	Identifies the specific other benefit category that is associated to the Other Benefit Type for the Date of Service requested.	N	01 = Dual Status Level
D28-MM	Other Benefit Detail Information Effective Date	The effective date of the other benefit detail information for the date of service requested.	N	
D33-MX	Other Benefit Detail Information Termination Date	The termination date of the other benefit detail information for the date of service requested.	N	
D31-MR	Other Benefit Detail Information Provider Number	The Other Benefit Detail Information Provider NPI (National Provider Identifier).	N	
D29-MN	Other Benefit Detail Information Facility Name	Name identifying the Other Benefit Detail Information Facility where the service was rendered.	N	
D30-MP	Other Benefit Detail Information Facility Telephone Number	Phone number of the Other Benefit Detail Information Facility.	N	
RESPONSE PROVIDER SEGMENT				
E87-ZV	Data Source Of Invalid Provider Determination	Identifies data source used to determine invalid provider status. This data may be obtained directly from the authoritative source or supplied through a vendor.	N	01 = OIG LEIE 03 = CMS Preclusion List
E88-ZZ	State Code For Data Source Of Invalid Provider Determination	Identifies the state from which the Invalid Provider Data Source originated.	N	

Name Changes

The following table identifies fields that have been renamed in F6.

Field ID	VD.0 Field Name	VF6 Field Name
101-A1	BIN Number	IIN Number
475-J9 476-H6 544-FY	DUR Co-Agent ID Qualifier DUR Co-Agent ID DUR Free Text Message	DUR/DUE Co-Agent ID Qualifier DUR/DUE Co-Agent ID DUR/DUE Free Text Message
482-GE 559-AX 560-AY	Percentage Sales Tax Amount Submitted Percentage Sales Tax Amount Paid Percentage Sales Tax Rate Paid	Percentage Tax Amount Submitted Percentage Tax Amount Paid Percentage Tax Rate Paid

Field ID	VD.0 Field Name	VF6 Field Name
561-AZ	Percentage Sales Tax Basis Paid	Percentage Tax Basis Paid
481-HA 558-AW	Flat Sales Tax Amount Submitted Flat Sales Tax Amount Paid	Regulatory Fee Amount Submitted Regulatory Fee Amount Paid
551-9F 552-AP 553-AR 554-AS 555-AT 556-AU	Preferred Product Count Preferred Product ID Qualifier Preferred Product ID Preferred Product Incentive Preferred Product Cost Share Incentive Preferred Product Description	Formulary Alternative Product Count Formulary Alternative ID Qualifier Formulary Alternative ID Formulary Alternative Incentive Formulary Alternative Estimated Patient Cost Share Formulary Alternate Description
483-HE 484-JE	Percentage Sales Tax Rate Submitted Percentage Sales Tax Basis Submitted	Percentage Tax Rate Submitted Percentage Tax Basis Submitted
557-AV	Tax Exempt Indicator	Percentage Tax Exempt Indicator
433-DX	Patient Paid Amount Submitted	Patient Paid Amount Reported
575-EQ	Patient Sales Tax Amount	Patient Percentage Tax Amount
348-HK 349-HM	Basis of Calculation – Flat Sales Tax Basis of Calculation – Percentage Sales Tax	Basis Of Calculation—Regulatory Fee Basis of Calculation – Percentage Tax
530-FU 531-FV	Previous Date of Fill Quantity of Previous Fill	Previous Date of Service Quantity of Previous Dispensing
462-EV	Prior Authorization Number Submitted	Prior Authorization ID Submitted

Removed Fields

The following table identifies fields that have been removed as part of the F6 standard.

Field ID	Field Name	Comment
314-CE	Home Plan	No longer used
392-MU 393-MV 394-MW	Benefit Stage Count Benefit Stage Qualifier Benefit Stage Amount	New Benefit Stage Indicator grouping of fields were introduced
138-UQ	CMS Low Income Cost Sharing (LICS) Level	New LIS Level field added in Response Other Related Benefit Detail Segment
486-ME 485-KE 487-NE	Coupon Number Coupon Type Coupon Value Amount	Coupon Segment removed
113-N3	Medicaid Paid Amount	Moved to subrogation standard
114-N4	Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)	Moved to subrogation standard
574-2Y	Plan Sales Tax Amount	
570-NS	DUR Additional Text	DUR/DUE Free Text Message field length was expanded
997-G2	CMS Part D Defined Qualified Facility	No longer needed

Replaced Fields

The following table highlights D.0 fields that are being deleted and replaced with a new field in F6.

Field ID	Field Name	Comment
498-PG	Authorized Representative Street Address	Replaced with new fields for Authorized Representative Address Line 1 (B13-7D) and Authorized Representative Address Line 2 (B14-8B)
316-CG	Employer Street Address	Replaced with new fields for Employer Street Address Line 1 (B15-8D) and Employer Street Address Line 2 (B16-7G)
321-CL	Employer Contact Name	Replaced with new fields for Employer Contact First Name (B17-7H) and Employer Contact Last Name (B18-7J)
322-CM	Patient Street Address	Replaced with new fields for Patient Street Address Line 1 (B08-7A) and Patient Street Address Line 2 (B09-7B)
121-TV	Pay To Street Address	Replaced with new fields for Pay to Street Address Line 1 (B24-7R) and Pay to Street Address Line 2 (B25-7S)
365-2K	Prescriber Street Address	Replaced with new fields for Prescriber Street Address Line 1 (B27-7U) and Prescriber Street Address Line 2 (B28-7V)
464-EX	Intermediary Authorization ID	Replaced with Intermediary ID Count (B44-8G), Intermediary ID Type Code (B45-8H), Intermediary ID Type Entity (B46-8J), Intermediary ID Qualifier (B47-8K), Intermediary ID (B48-8M) as part of the new Intermediary segment
463-EW	Intermediary Authorization Type ID	
517-FH	Amount Applied To Periodic Deductible	Replaced with Patient Pay Component Qualifier (C95-KQ) value 01
137-UP	Amount Attributed to Coverage Gap	Replaced with Patient Pay Component Qualifier (C95-KQ) value 12
571-NZ	Amount Attributed to Processor Fee	Replaced with Patient Pay Component Qualifier (C95-KQ) value 13
134-UK	Amount Attributed to Product Selection / Brand Drug	Replaced with Patient Pay Component Qualifier (C95-KQ) value 02
136-UN	Amount Attributed to Product Selection / Brand Non-Preferred Formulary Selection	Replaced with Patient Pay Component Qualifier (C95-KQ) value 11
135-UM	Amount Attributed to Product Selection / Non-Preferred Formulary Selection	Replaced with Patient Pay Component Qualifier (C95-KQ) value 08
133-UJ	Amount Attributed to Provider Network Selection	Replaced with Patient Pay Component Qualifier (C95-KQ) value 10
523-FN	Amount Attributed To Sales Tax	Replaced with Patient Pay Component Qualifier (C95-KQ) value 03
520-FK	Amount Exceeding Periodic Benefit Maximum	Replaced with Patient Pay Component Qualifier (C95-KQ) value 04
572-4U	Amount of Coinsurance	Replaced with Patient Pay Component Qualifier (C95-KQ) value 07
518-FI	Amount Of Copay	Replaced with Patient Pay Component Qualifier (C95-KQ) value 05
392-MU	Benefit Stage Count	Replaced with Benefit Stage Indicator Count (C50-9W)
393-MV	Benefit Stage Qualifier	Replaced with Benefit Stage Indicator (C51-9X)
129-UD	Health Plan-funded Assistance Amount	Replaced with Patient Pay Component (C95-KQ) value 09
550-8F	Help Desk Telephone Number	Replaced with new grouping of fields for Help Desk Replaced with Help Desk Support Type Count (C72-BH), Help Desk Support Type (C71-BG), Help Desk Business Unit Type Count (C67-BB), Help Desk Business Unit Type (C66-BA), Help Desk Contact Information Qualifier (C70-BF), Help Desk Contact Information (C68-BC) and Help Desk Contact Information Extension (C69-BD).
549-7F	Help Desk Telephone Number Qualifier	

Field ID	Field Name	Comment
990-MG	Other Payer BIN Number	Replaced with N Payer IIN (C52-9Y) in N Transaction Payer Identification Segment
987-MA	URL	Replaced with Help Desk Support Type Count (C72-BH), Help Desk Support Type (C71-BG), Help Desk Business Unit Type Count (C67-BB), Help Desk Business Unit Type (C66-BA), Help Desk Contact Information Qualifier (C70-BF), Help Desk Contact Information (C68-BC) and Help Desk Contact Information Extension (C69-BD).

Field Size Changes

The following table identifies fields whose lengths have changed in F6.

Field ID	Field Name	VD.0 Length	VF6 Length
101-A1	IIN Number	6	8
120-TU	Pay to Name	20	70
126-UA	Generic Equivalent Product ID	19	40
128-UC	Spending Account Amount Remaining	8	11
148-U8	Ingredient Cost Contracted/ Reimbursable Amount	8	11
149-U9	Dispensing Fee Contracted/ Reimbursable Amount	8	11
340-7C	Other Payer ID	10	30
352-NQ	Other Payer-Patient Responsibility Amount	10	11
364-2J	Prescriber First Name	12	15
381-4H	Question Dollar Amount Response	11	14
385-3Q	Facility Name	30	70
407-D7	Product/Service ID	19	40
409-D9	Ingredient Cost Submitted	8	11
411-DB	Prescriber ID	15	35
412-DC	Dispensing Fee Submitted	8	11
420-DK	Submission Clarification Code	2	3
421-DL	Primary Care Provider ID	15	35
426-DQ	Usual and Customary Charge	8	11
427-DR	Prescriber Last Name	15	35
429-DT	Special Packaging Indicator	1	2
430-DU	Gross Amount Due	8	11
431-DV	Other Payer Amount Paid	8	11
433-DX	Patient Pay Amount Reported	8	11
438-E3	Incentive Amount Submitted	8	11
444-E9	Provider ID	15	35
445-EA	Originally Prescribed Product/Service Code	19	40
448-ED	Compound Ingredient Quantity	10	14
449-EE	Compound Ingredient Drug Cost	8	11
450-EF	Compound Dosage Form Description Code	2	15
454-EK	Scheduled Prescription ID Number	12	30
470-4E	Primary Care Provider Last Name	15	35
476-H6	DUR/DUE Co-Agent ID	19	40
477-BE	Professional Service Fee Submitted	8	11
480-H9	Other Amount Claimed Submitted	8	11
481-HA	Regulatory Fee Amount Submitted	8	11
482-GE	Percentage Tax Amount Submitted	8	11
489-TE	Compound Product ID	19	40
498-PE	Authorized Representative First Name	12	35
498-PF	Authorized Representative Last Name	15	35

Field ID	Field Name	VD.0 Length	VF6 Length
498-RB	Prior Authorization Dollars Authorized	8	11
505-F5	Patient Pay Amount	8	11
506-F6	Ingredient Cost Paid	8	11
507-F7	Dispensing Fee Paid	8	11
509-F9	Total Amount Paid	8	11
512-FC	Accumulated Deductible Amount	8	11
513-FD	Remaining Deductible Amount	8	11
514-FE	Remaining Benefit Amount	8	11
521-FL	Incentive Amount Paid	8	11
544-FY	DUR/DUE Free Text Message	30	360
553-AR	Formulary Alternative ID	19	40
554-AS	Formulary Alternative Incentive	8	11
555-AT	Formulary Alternative Estimated Cost Share	8	11
558-AW	Regulatory Fee Amount Paid	8	11
559-AX	Percentage Tax Amount Paid	8	11
562-J1	Professional Service Fee Paid	8	11
565-J4	Other Amount Paid	8	11
566-J5	Other Payer Amount Recognized	8	11
575-EQ	Patient Percentage Tax Amount	8	11
577-G3	Estimated Generic Savings	8	11
880-K5	Transaction Reference Number	10	30
926-FF	Formulary ID	10	40

Repetition Changes

The following table identifies fields whose repetition limits have changed in F6 OR a repetition has been introduced.

Field ID	Field Name	VD.0 Count	VF6 Count	Change
337-4C	Coordination of Benefits/Other Payments Count	9	3	Decrease
355-NT	Other Payer ID Count	3	4	Increase
354-NX	Submission Clarification Code Count	3	5	Increase
618-RR	Patient ID Count	N/A	9	New
D60-RK	Regulatory Fee Count	N/A	3	New

Field Format Changes

The following table identifies fields whose format requirements have changed in F6.

x( ) = alphanumeric 9( ) = numeric ECS = email character set

Field ID	Field Name	VD.0 Format	VF6 Format
350-HN	Patient E-Mail address	x(80)	ECS(80)
462-EV	Prior Authorization ID Submitted	9(11)	x(35)
483-HE	Percentage Tax Rate Submitted	S9(3)v9999 *Ex: s$$$.cccc*	9(3)v9999 *Ex: 999.9999*
560-AY	Percentage Tax Rate Paid	S9(3)v99994 *Ex: s$$$.cccc*	9(3)v9999 *Ex: 999.9999*

Situation Changes

The following table identifies fields whose situation of use has changed in F6. The verbiage in bold indicates the change.

Field ID	Field Name	Request or Response?	D.0 Situation	F6 Situation
307-C7	Place of Service	Request	Required if this field could result in different coverage, pricing, or patient financial responsibility.	Required if necessary for state/federal/regulatory agency programs. **Otherwise, required when necessary to identify the Place of Service for non-self administered drugs**
460-ET	Quantity Prescribed	Request	Required for Schedule II controlled substance claims	Required for **all** controlled substance claims **or for other products as required by law**
569-J8	Payer/Health Plan ID	Response	Required to identify the ID of the payer responding.	Required when identification of the Payer/Health Plan is necessary. **Required when the claim was paid by a Medicare Part D Plan/Payer. The value of 05 (Medicare Part D Contract Number) must be sent in the Payer/Health Plan ID Qualifier (568-J7) and the Medicare Part D Contract Number must be sent in this field.**
498-PT	Prior Authorization Expiration Date	Response	Not Used	**Required when the prior authorization expiration date is known.**

Additional Context for Key Changes

BIN to IIN

The Bank Identification Number (BIN) has been renamed the Issuer Identification Number (IIN). Version D.0 supports only the 6-digit BIN, while version F6 supports only the 8-digit IIN.

IINs may end in values ranging from "00" to "99"; however, during the transition from vD.0 to vF6, only IINs ending in "00" should be used. Existing 6-digit BINs will be updated with the "00" added at the **end** to reflect an 8-digit IIN.

Use of IINs ending in "01–99" must be coordinated with NCPDP to prevent potential claim routing issues. NCPDP will work with ANSI to assign IINs ending in "01–99" for healthcare entities.

Submission Clarification Code to Submission Type Code

The Submission Clarification Code (SCC) field (420-DK) is intended to be used when a claim needs to bypass plan benefit limitations that would typically result in a reject. However, certain SCC values have been designated as information only and are meant to support reporting purposes rather than override rejections. To address this, a new field, Submission Type Code (STC) (D17-K8), was introduced in F6 to house those informational use cases.

The key difference between the STC and SCC can be summarized as defining the distinction between “what and “why” in a submission.

- The STC (“what”) identifies the nature or category of the submission (for example, 340B, encounter, or split bill). This ensures the processor has the necessary context to properly adjudicate the claim or trigger any downstream processing requirements.
- The SCC (“why”) provides context for the submission, explaining the reason the claim is being sent in situations where it might not typically qualify for coverage under standard circumstances.

The table below lists SCC values which will move to the Submission Type Code (D17-K8) field. The value descriptions remained the same between the two data elements.

Submission Type	Description	D.0 SCC Value*	F6 STC Value
340B	Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8)).	20	AA
Split Billing	Indicates the Quantity Dispensed (442-E7) is the remaining quantity billed to a subsequent payer when Medicare Part A no longer applies. Used only in long term care settings.	19	AB
Encounter	Indicates the transaction is a transmission of provider services claim information for the purpose of healthcare reporting.	09	AC
Nominal Price	Indicates that, prior to providing service, the pharmacy has determined the product being billed is based on the negotiated Nominal Price as defined under CFR 557.502.	58	AD
Federal Supply Schedule	Indicates that, prior to providing service, the pharmacy has determined the product being billed is based on the Federal Supply Schedule also called "multiple award schedules" and "GSA schedules", where government agencies can obtain supplies and services at prices associated with volume buying. There are multiple buying schedules where Pharmaceuticals and Drugs fall under 65 I B (= Veterans Administration) which is the price for pharmaceuticals available to federal entities that purchase prescription drugs.	59	AE
Synchronization Fill – Shortened Days Supply	Indicates a shortened days supply is being dispensed to synchronize the dates of service across multiple medications	61	AF
Trial Fill – Shortened Days Supply -	Indicates a shortened days supply is being dispensed for purposes of a trial fill.	64	AG

*SCC values are not available for use in Version F6.

Patient Pay Component

The new **Patient Pay Component** structure was introduced in F6 to display the patient's total cost share into individual, repeatable components instead of relying on multiple separate D.0 fields that were added together to make up the Patient Pay Amount (505-F5).
In F6, this is displayed through three related fields (repeatable up to 25 values):

- **C94-KP – Patient Pay Component Count**: Identifies how many component entries are being reported.
- **C95-KQ – Patient Pay Component Qualifier**: Identifies what type of patient-pay component the amount represents, such as copay, coinsurance, deductible, tax, product selection, coverage gap, etc.
- **C93-KN – Patient Pay Component Amount**: Reports the dollar amount tied to that specific component.

This new setup makes it easier to understand how patient costs are calculated, supports new program designs, and allows ECL values to be added more quickly. It also makes it easier to align and map values when processing COB claims.

The chart below displays the VD.0 fields that have been removed and the mapping to the new Patient Pay Component Qualifiers (C95-KQ).

Patient Pay Component Amount	Removed D.0 Field ID	VF6 Patient Pay Component Qualifier
Amount Applied to Periodic Deductible	517-FH	01
Amount Attributed to Product Selection/Brand Drug	134-UK	02
Amount Attributed to Percentage Tax	523-FN	03
Amount Exceeding Periodic Benefit Maximum	520-FK	04
Amount of Copay	518-FI	05
Amount of Coinsurance	572-4U	07
Amount Attributed to Product Selection/Non-Preferred Formulary Selection	135-UM	08
Amount Attributed to Health Plan Assistance Amount	129-UD	09
Amount Attributed to Provider Network Selection	133-UJ	10
Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection	136-UN	11
Amount Attributed to Coverage Gap	137-UP	12
Amount Attributed to Processor Fee	571-NZ	13
Amount Attributed to Grace Period	N/A	14
Amount Attributed to Catastrophic Benefit	N/A	15
Amount Attributed to Unbalanced Patient Pay (OPPRA)	N/A	16
Amount Attributed to Regulatory Fee	N/A	17
Amount Attributed to Spend Down	N/A	18
Patient Responsibility not associated with Medicare Prescription Payment Plan	N/A	19

Compound Level of Complexity

A new field Compound Level of Complexity (C60-AG) was introduced in the Compound Segment, **replacing the use of DUR/PPS Level of Effort (474-8E)** for describing compounding complexity and aligns more naturally with pharmacy workflows by consolidating compounding-related data within a single segment.

With the implementation of Telecommunication Standard Version F6, the following updates apply:

DUR/PPS Level of Effort (474-8E)

- Values 11–15:
    - Allowed for all claim types, including compounds, in Version D.0 **ONLY**
    - **Not permitted for compound claims in F6**
    - There is no direct mapping for these values to the new Compound Level of Complexity values

With Version F6, the following values will be used to determine the appropriate compound preparation fee (if applicable) to the pharmacy:

Compound Level of Complexity Value	Description
01	Low Level Complexity *Non-sterile compounding, non-hazardous compound active pharmaceutical ingredients (API), 2 or more active ingredients combined in a simple one step procedure.*
10	Mid-Level Complexity Non-Hazardous *Non-sterile compounding, non-hazardous compound active pharmaceutical ingredients (API), whereby two or more API are mixed together with added complexity of melting, diluting, solubilizing, heating, two phase mixing, aliquot, with final form being something other than a simple cream.*
20	Mid-Level Complexity Hazardous *Non-sterile but manipulating hazardous active pharmaceutical ingredients (API).*
31	High Level Non-Hazardous Sterile *Sterile to Sterile compounding with non-hazardous active pharmaceutical ingredients (API).*
41	High Level Hazardous Sterile *Sterile to Sterile compounding with hazardous active pharmaceutical ingredients (API).*
51	High Level Non-Hazardous *Non-sterile to Sterile compounding with non-hazardous active pharmaceutical ingredients (API).*
61	High Level Hazardous *Non-sterile to Sterile compounding with hazardous active pharmaceutical ingredients (API).*

Help Desk Phone Number/Contact Information

In VD.0, Help Desk information is limited to a single occurrence of the Help Desk Phone Number (550-8F) field. In F6, separate help desk fields have been introduced to better support automated processing. These fields are organized as repeating groups, enabling up to 25 sets of help desk contact information to be returned. This structure supports system-driven extraction and use of the information, such as automatically connecting or communicating with the appropriate party (e.g., pharmacy, prescriber, or patient). This structure also provides additional information regarding the individual responsible for contacting the provided help desk contact information (i.e., member, pharmacy, prescriber).

- **Help Desk Support Type (C71-BG)** field indicates the intended entity responsible for contacting the help desk. This may be pharmacy staff, prescriber, patient (member) or all three if multiple actions are needed for the associated transaction
- **Help Desk Business Unit Type (C66-BA)** field indicates the type of help desk support available (e.g., pharmacy help desk, clinical/prior authorization, health plan, third party liability eligibility management)

- **Help Desk Contact Information (C68-BC)** field reports the phone/email/etc. of the help desk needing to receive the call

Example:
This response would indicate the pharmacy (Help Desk Support Type) is responsible for contacting the pharmacy help desk (Help Desk Business Unit Type) telephone number (Help Desk Contact Information).

Field	Description	Value	Comments
C72-BH	Help Desk Support Type Count	1	1 Occurrence
C71-BG	Help Desk Support Type	1	Pharmacy
C67-BB	Help Desk Business Unit Type Count	1	1 Occurrence
C66-BA	Help Desk Business Unit Type	1	Pharmacy Help Desk
C70-BF	Help Desk Contact Information Qualifier	1	Telephone Number
C68-BC	Help Desk Contact Information	5558675309	

Adjudicated Program Type

The Adjudicated Program Type identifies the type of prescription benefit plan or program under which an F6 claim was adjudicated and is **required for all paid claim transactions**. It helps clarify whether the claim was adjudicated under a program such as Medicaid, Medicare, Commercial, Workers' Compensation, Medicare Part D, Medicare Part B, Tricare, or another defined program type.

The adjudicated program type value returned on the response may also be used in coordination of benefits processing. When a pharmacy submits a subsequent COB claim, the value from the prior payer's response can be passed as **Other Payer Adjudicated Program Type (C47-9T)**. This allows the next payer to understand what type of program adjudicated the prior claim and apply the appropriate coordination rules. For example, a secondary payer may need to know whether the prior payer was Medicare, Medicaid, a discount program, or another benefit type before determining whether the COB claim can be accepted.

Tax Field Changes and Regulatory Fees

F6 updates tax reporting by separating percentage-based tax from regulatory fee amounts. In F6, the terminology is broader and more precise: percentage sales tax fields are renamed to percentage tax fields, while flat sales tax fields are renamed to regulatory fee fields. This change supports clearer reporting when an amount is not a traditional sales tax but is instead a state, local, or program-specific regulatory fee.

F6 also introduces a repeatable Regulatory Fee structure in the Pricing and Response Pricing segments. Regulatory Fee Count (D60-RK) identifies how many regulatory fee entries are being reported, Regulatory Fee Type Code (D61-RL) identifies the type of regulatory fee, and Regulatory Fee Exempt Indicator (D62-RM) identifies the source of the claim's regulatory fee exempt status. The regulatory fee grouping can repeat up to three times, allowing multiple fee types to be reported on a single transaction.

COB reporting is also expanded for other payer regulatory fees. F6 includes Other Payer Regulatory Fee Type Count (D53-P9), Other Payer Regulatory Fee Type Code (D63-RN), and Other Payer Regulatory Fee Exempt Indicator (D52-P8). These

fields allow a secondary or downstream payer to understand what regulatory fee information was reported by the previous payer and whether any exemption applied.

These changes are useful because they improve clarity, reduce reliance on sales-tax-specific terminology, and support more accurate adjudication, COB processing, accumulator handling, reporting, and audit review. They also help distinguish patient responsibility tied to percentage tax from regulatory fee obligations, including situations where benefit design passes a regulatory fee directly to the patient through Patient Regulatory Fee Amount (D65-RS).