Pharmacy Claims Data Request

Sympl Benefits is requesting pharmacy claims data for the purposes of evaluating our PBM performance to present a savings and opportunity analysis.

Data Requirements

❖ Please provide pharmacy claims data for your most recent full plan year (e.g., claims with Service Dates between January 1, 2024, and December 31, 2024). **Two years of data is preferred (include prior plan year).**

❖ For confidentiality purposes, please ensure that any member information provided is de-identified blinded, or scrambled. **The file should not contain any PII/PHI.**

❖ Pharmacy claims should be provided at the claim line-level, meaning that for most claims, we will see a line per Rx fill. Each row of data in the file should represent one claim line (or Rx fill)

❖ Please be sure to include leading zeros for any data element where this may be applicable.

❖ Request/Send the data elements in the format specified in the table at the end of this document.

File Format and Data Transfer

❖ Send the pharmacy claims file as a .xlsx or .csv file.

❖ Send the pharmacy claims file via email. While the file should not contain any PII/PHI, for confidentiality purposes, we still recommend encrypting the file before sharing with us. Please include instructions for decryption. (PW, secure FTP, etc)

❖ If the file is too large to send via email, please contact help@symplbenefits.com. We are happy to create a secure file transfer protocol via MS Sharepoint.

Please reach out to help@symplbenefits.com if you have any questions or need any assistance with this data request.

Pharmacy Claims Data Specifications

Column	Data Element	Data Type	Required	Description	Example
1	NDC	Number	Required	The National Drug Code (NDC) is a unique 10 or 11-digit identifier used in the United States for drugs intended for human use, consisting of three segments that identify the labeler, product, and package size.	00310520530
2	Date of Service	Date	Required	Date of drug fill (MM/DD/YYYY	01/01/2025
3	Quantity	Number	Required	Quantity of doses	30
4	Days Supply	Number	Required	Days supply at recommended dosage	30
5	Dispensing Indicator	Number	Optional	DAW	2
6	Brand/Generic	Text	Required	Brand/Generic	Brand
7	Member ID (scrambled)	Number	Required	Unique Identifier of the member obtaining drug fill.	1541544321
8	NABP	Number	Required	Drug Distributor NABP Identifier (7 Digits)	2372996
9	NPI	Number	Required	The National Provider Identifier (NPI) is a unique 10-digit number assigned to healthcare providers for identification in standard transactions, including drug prescriptions.	1447480835
10	Pharmacy Type	Text	Required	Retail / Mail Order / Specialty	Retail
11	Compound Indicator	Yes/No	Required	Is the medication compounded?	No
12	Formulary Tier	Text	Required	Identify the Formulary Tier for each drug fill	Tier 1 (Generic)
13	AWP	Number	Required	Average Wholesale Price	$259.33
14	U&C	Number	Required	Usual and Customary Cost	$289.67
15	Ingredient Cost Paid	Number	Required	Ingredient cost paid by plan	$222.74
16	Dispensing Fee	Number	Required	Dispensing fee paid by plan	$0.90
17	Plan Payment	Number	Required	Amount paid by plan	$203.64
18	Member Payment	Number	Required	Amount paid by member	$20.00
19	Amount Applied to Member Deductible	Number	Required	Amount applied to member's deductible (if any) – typically applies to QHDP, or non-copay plan.	$0.00
20	Amount Applied to Member Copay	Number	Required	Copay amount paid by member	$20.00
21	Drug Cost Basis	Text	Required	Methodology used for price of drug. (AWP, MAC, U&C, State MAC, $0Vaccine, Compound, etc.)	AWP
22	Fill Number	Number	Optional	Count of same drug fills for same member in a plan year. (Example 1st fill = 1, 12th fill =12)	8
23	Unique Claim Identifier	Number	Optional	PBM/TPA's unique identifier for each fill	000000000002 4130396979100 5997P
24	J Code Identifier	Yes/No	Optional	Was this medication filled through medical plan? (J-Code, etc.)	Yes/No
25	Drug Name	Text	Required	Common name of drug	SULFAMETHOXA ZOLE/TRIMETHO PRIM DS
26	Drug Strength	Text	Required	Dosage Strength (MG, ML, etc.)	200MG
27	Drug Dosage Form	Text	Required	Type of drug administration (TAB, CAP, PNKT, SOAJ, SOPN, CPCR, etc.)	CAP
28	Member Relationship	Text	Required	Subscriber/Spouse/Child/Other Dependent	Subscriber
29	Member Date of Birth	Date	Required	MM/DD/YYYY	08/19/1981

30	Pharmacy Name	Text	Required	Name of dispensing pharmacy	ACCREDO HEALTH GROUP, INC.
31	Pharmacy Zip Code	Number	Required	Zip code of pharmacy	49341
32	Specialty Indicator	Yes/No	Required	Is the drug considered a specialty drug?	No
33	Prescriber NPI	Number	Required	A prescriber NPI (National Provider Identifier) is a unique 10-digit number assigned to healthcare providers who prescribe medications	1942165178
34	Prescriber First Name	Text	Required	First name of prescribing physician	Tom
35	Prescriber Last Name	Text	Required	Last name of prescribing physician	Jones