ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
201	BILLING PROVIDER ID MISSING	1210	The Billing Provider ID or NPI number is	16	Claim/service lacks information or has	N257	Missing/incomplete/invalid billing
			missing.		submission/billing error(s). Usage: Do not		provider/supplier primary identifier.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation net y, n present		
202	1ST PATIENT REASON FOR VISIT CODE	7433	1st Patient Reason for Visit is Invalid.	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
	INVALID				service reported.		condition.
203	CLIENT I.D. NUMBER MISSING	129	Recipient's ID Number is Missing or Not in	16	Claim/service lacks information or has	N382	Missing/incomplete/invalid patient
			Valid Format.		submission/billing error(s). Usage: Do not		identifier.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
204	1ST EXTERNAL CAUSE OF INJURY	1900	1st External Cause of Injury Code is	16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or
204	DIAGNOSIS INVALID	1500	invalid. Correct the external cause of	10	submission/billing error(s). Usage: Do not	1417 0	condition.
	DIN CONTROL OF THE PARTY OF THE		injury code.		use this code for claims		contaction
			injury couc.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
207	2ND PATIENT REASON FOR VISIT CODE	7434	2nd Patient Reason for Visit is Invalid.	146	Diagnosia was invalid for the data (a)	NA7.C	Missing linear moleta linear linear attaches
207	INVALID	/454	znu ratient keason for Visit is Invalid.	140	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
209	DATE PRESCRIBED IS INVALID	242	Prescription Date is invalid.	16	Claim/service lacks information or has	N57	Missing/incomplete/invalid prescribing
					submission/billing error(s). Usage: Do not		date.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					I =		
					Information REF), if present.		
		1	1	l	1		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
210	BILLED AMOUNT > 999999.99	210	BILLED AMOUNT > 999999.99	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid charge.
211	REFILL INDICATOR INVALID	1801	REFILL INDICATOR INVALID.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
212	PRESCRIPTION NUMBER IS MISSING/INVALID	3203	Denied. Prescription Number Is Missing Or Invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid prescription number.
215	DATE DISPENSED IS MISSING	1803	DISPENSE DATE OF SERVICE REQUIRED.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid dispensed date.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
216	DATE DISPENSED IS INVALID	1385	Dispense date of service is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N304	Missing/incomplete/invalid dispensed date.
217	NDC MISSING	217	NDC MISSING	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
218	NDC IS NOT NUMERIC	218	NDC is not numeric	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
219	Invalid NDC quantity	543	Please Indicate Quantity Dispensed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
220	QUANTITY DISPENSED IS INVALID	224	Quantity dispensed is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.
221	DAYS SUPPLY IS ZERO	1286	Days supply is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
222	DAYS SUPPLY INVALID	203	Days supply is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
223	HEADER QUANTITY DISPENSED IS MISSING	ā 543	Please Indicate Quantity Dispensed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
224	HEADER QUANTITY DISPENSED IS INVALID	224	Quantity dispensed is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (Ioop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.
225	3RD PATIENT REASON FOR VISIT CODE INVALID	7435	3rd Patient Reason for Visit is Invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
226	DETAIL UNITS BILLED GREATER THAN 9999	226	DETAIL NUMBER OF UNITS BILLED IS GREATER THAN 9,999.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
227	THIRD PARTY PAYMENT AMOUNT INVALID	81	Primary Carrier Pay missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N58	Missing/incomplete/invalid patient liability amount.
228	BILLING PROVIDER SIGNATURE MISSING	4060	The provider's signature is missing. Complete signature field indicator, or include signature certification page for the dental or UB04 forms.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA70	Missing/incomplete/invalid provider representative signature.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
229	SOURCE OF ADMISSION MISSING/INVALID	1291	Valid Source of Admission is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA42	Missing/incomplete/invalid admission source.
231	PERFORMING PROVIDER NUMBER IS MISSING	1209	Rendering Provider is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
233	QUANTITY BILLED MISSING	1830	The units of service are missing or invalid. Enter/Correct the units of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
234	PROCEDURE CODE MISSING	1720	The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
235	PROCEDURE CODE NOT IN VALID FORMAT	1720	The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
236	NDC QUANTITY BILLED > 9999999.999	236	NDC QUANTITY BILLED > 9999999.999	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
237	CLIENT FIRST NAME IS MISSING OR DOES NOT MATCH	614	FIRST NAME IS MISSING OR DOES NOT MATCH MEMBER ID.	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.
238	CLIENT LAST NAME IS MISSING OR DOES NOT MATCH	29	LAST NAME IS MISSING OR DOES NOT MATCH MEMBER ID.	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.
239	THE DETAIL "TO" DATE OF SERVICE IS MISSING	4070	The last date of service is missing or invalid. Enter/Correct the last date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
240	DETAIL TDOS DATE IS INVALID	1261	Detail To Date of Service is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
242	SECONDARY DIAGNOSIS CODE INVALID FORMAT	1148	Second Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
244	THIRD DIAGNOSIS CODE INVALID FORMAT	1149	Third Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
245	MISSING OCCURRENCE CODE	1129	Occurrence Code is required when an Occurrence Date is present.	16		M45	Missing/incomplete/invalid occurrence code(s).
246	FOURTH DIAGNOSIS CODE INVALID FORMAT	1150	Fourth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
247		5310	The detail lines are missing or the maximum number of lines has been exceeded. Enter the detail lines. If the maximum number is exceeded, split the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
248	PLACE OF SERVICE INVALID FORMAT	150	Place of Service is Missing or Invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
249	PLACE OF SERVICE NOT ON FILE	1278	Place of Service code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
250	CLAIM HAS NO DETAILS	5310	The detail lines are missing or the	16	Claim/service lacks information or has	M53	Missing/incomplete/invalid days or units
			maximum number of lines has been		submission/billing error(s). Usage: Do not		of service.
			exceeded. Enter the detail lines. If the		use this code for claims		
			maximum number is exceeded, split the		attachment(s)/other documentation. At		
			claim.		least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information KET J, it present.		
254	FIRST MODIFIED INVALID	2472		400	D 1 100 1 111 11	NG57	T
251	FIRST MODIFIER INVALID	3170	The first modifier code is invalid.	182	Procedure modifier was invalid on the	N657	This should be billed with the appropriate
252	SECOND MODIFIED INVALID	2474	T 100 100 101	400	date of service.	N.CET	code for these services.
252	SECOND MODIFIER INVALID	3171	The second modifier code is invalid.	182	Procedure modifier was invalid on the	N657	This should be billed with the appropriate
					date of service.		code for these services.
253	THIRD MODIFIER INVALID	1127	The third modifier code is invalid.	182	Procedure modifier was invalid on the	N657	This should be billed with the appropriate
					date of service.		code for these services.
255	TENTH DIAGNOSIS INVALID FORMAT	1170	Tenth diagnosis is invalid.	146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other
					service reported.		diagnosis.
256	ELEVENTH DIAGNOSIS INVALID FORMAT	1171	Eleventh diagnosis is invalid.	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
					service reported.		condition.
257	PRIMARY DIAGNOSIS CODE MISSING -	1630	The principal ICD diagnosis code is	16	Claim/service lacks information or has	MA63	Missing/incomplete/invalid principal
	DETAIL		missing. Enter the ICD diagnosis code.		submission/billing error(s). Usage: Do not		diagnosis.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
250	DDIMARRY DIA CNIGGIG CODE MISSING	4620	The adjusted ICD discussioned :	4.6		MAG2	Adiation time and the discounties and
258	PRIMARY DIAGNOSIS CODE MISSING -	1630	The principal ICD diagnosis code is	16	Claim/service lacks information or has	MA63	Missing/incomplete/invalid principal
	HEADER		missing. Enter the ICD diagnosis code.		submission/billing error(s). Usage: Do not		diagnosis.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
259	DATE BILLED IS MISSING/INVALID	259	DATE BILLED IS MISSING/INVALID.	16	Claim/service lacks information or has	M53	Missing/incomplete/invalid days or units
					submission/billing error(s). Usage: Do not		of service.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
260	DTL UNITS BILLED NOT IN VALID FORMAT	1830	The units of service are missing or invalid.	16	Claim/service lacks information or has	M53	Missing/incomplete/invalid days or units
			Enter/Correct the units of service.		submission/billing error(s). Usage: Do not		of service.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
261	TOOTH NUMBER MISSING	1800	The tooth number is invalid/missing.	16	Claim/service lacks information or has	N37	Missing/incomplete/invalid tooth
			Correct the tooth number.		submission/billing error(s). Usage: Do not		number/letter.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
262	TOOTH NUMBER INVALID	1800	The tooth number is invalid/missing.	16	Claim/service lacks information or has	N37	Missing/incomplete/invalid tooth
			Correct the tooth number.		submission/billing error(s). Usage: Do not		number/letter.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
			1				

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
263	TOOTH SURFACE CODE INVALID	220	Tooth surface is invalid or not indicated.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N75	Missing/incomplete/invalid tooth surface information.
264	DETAIL FDOS IS MISSING	1240	The from date of service is missing or invalid. Enter/Correct the from date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
265	DETAIL FDOS IS INVALID	1240	The from date of service is missing or invalid. Enter/Correct the from date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
266	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES	697	The number of tooth surfaces indicated is insufficient for the procedure code billed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N75	Missing/incomplete/invalid tooth surface information.
267	TWELFTH DIAGNOSIS INVALID FORMAT	1172	Twelfth diagnosis is invalid	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
268	BILLED AMOUNT MISSING	221	The detail billed amount is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
269	DETAIL BILLED AMOUNT INVALID	221	The detail billed amount is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
270	HEADER TOTAL BILLED AMOUNT MISSING	1271	The Total Billed Amount is missing or incorrect.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
271	HEADER TOTAL BILLED AMOUNT INVALID	153	The header total billed amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
272	PRIMARY DIAGNOSIS CODE INVALID FORMAT	1160	Primary Diagnosis Code is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
273	TYPE OF BILL MISSING	4100	The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the U804 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
274	TYPE OF BILL CODE INVALID	4100	The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the U804 Provider Manual or Help Screens for valid codes.		Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
275	ADMIT DATE MISSING	1850	The admission date is missing or invalid. Enter/Correct the admission date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
276	ADMIT DATE INVALID	1850	The admission date is missing or invalid. Enter/Correct the admission date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.
277	ADMIT HOUR INVALID	1860	The admission hour is missing or invalid. Enter the admission hour.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.] Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N46	Missing/incomplete/invalid admission hour.
278	ADMIT TYPE MISSING	2000	The type of admission is missing or invalid. Enter/Correct the type of admission. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA41	Missing/incomplete/invalid admission type.
279	ADMIT TYPE IS INVALID	2000	The type of admission is missing or invalid. Enter/Correct the type of admission. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA41	Missing/incomplete/invalid admission type.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
280	PATIENT STATUS IS MISSING	1267	The Patient Status code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid patient status.
281	PATIENT STATUS IS INVALID	1175	The Patient Status Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid patient status.
282	COVERED DAYS MISSING	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid number of covered days during the billing period.
283	COVERED DAYS INVALID	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid number of covered days during the billing period.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
284	1ST CONDITION CODE INVALID	181	The 1st condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
285	2ND CONDITION CODE INVALID	4122	The 2nd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
286	3RD CONDITION CODE INVALID	4123	The 3rd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
287	4TH CONDITION CODE INVALID	4124	The 4th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
288	5TH CONDITION CODE INVALID	4125	The 5th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
289	6TH CONDITION CODE INVALID	4126	The 6th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
290	7TH CONDITION CODE INVALID	4127	The 7th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
291	1ST OCCURRENCE CODE INVALID	730	1st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
292	2ND OCCURRENCE CODE INVALID	731	2nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
293	3RD OCCURRENCE CODE INVALID	732	3rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
294	4TH OCCURRENCE CODE INVALID	733	4th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
295	1ST OCCURRENCE CODE DATE MISSING	730	1st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
296	1ST OCCURRENCE CODE DATE INVALID	730	1st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
297	2ND OCCURRENCE CODE DATE MISSING	4082	2nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
298	2ND OCCURRENCE CODE DATE INVALID	4082	2nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
299	3RD OCCURRENCE CODE DATE MISSING	4083	3rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
300	3RD OCCURRENCE CODE DATE INVALID	4083	3rd Occurrence Code/Date invalid or	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		date(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KET J, it present.		
301	4TH OCCURRENCE CODE DATE MISSING	4084	4th Occurrence Code/Date invalid or	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		date(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
302	4TH OCCURRENCE CODE DATE INVALID	4084	4th Occurrence Code/Date invalid or	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		date(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KEI J, ii present.		
202		lea-		4.0		N.CO	
303	CLAIM DOS OVERLAP THE ICD VERSION	67	The claim dates of service overlap the ICD	10	Claim/service lacks information or has	N62	Dates of service span multiple rate
	EFFECTIVE DATE		version effective date. No overlap is		submission/billing error(s). Usage: Do not		periods. Resubmit separate claims.
			allowed between ICD9 and ICD10. Claim		use this code for claims		
			must be split.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
304	DISCHARGE HOUR INVALID	2451	The discharge hour is invalid. Please correct the discharge hour.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N317	Missing/incomplete/invalid discharge hour.
310	HMO ID INVALID	1824	HMO ID is invalid or not present on encounter claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N245	Incomplete/invalid plan information for other insurance.
313	MISSING INVALID COVERED-NON COVERED DAYS	1920	The medical leave days/non-covered days are missing or invalid. Enter/Correct the number of medical leave days and/or the non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
332	ENCOUNTER POS = 21 HOSP ADMIT DATE MISSING/INVALID	2400	Encounter Place of Service is 21 and Hospital Admit Date is Missing or Invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
339	REVENUE CODE IS MISSING	3751	The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
340	REVENUE CODE IS INVALID	3751	The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
350	NUMBER OF DTLS NOT EQUAL TO HDR DTL COUNT	1740	The number of details is not equal to the header detail count.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
355	5TH DIAGNOSIS CODE INVALID FORMAT	1151	The Fifth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
356	6TH DIAGNOSIS CODE INVALID FORMAT	1152	The Sixth Diagnosis Code is invalid.	146		M76	Missing/incomplete/invalid diagnosis or condition.
357	7TH DIAGNOSIS CODE INVALID FORMAT	1153	The Seventh Diagnosis Code is invalid.	146	service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
358	8TH DIAGNOSIS CODE INVALID FORMAT	1154	The Eighth Diagnosis Code is invalid.	146	service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
359	9TH DIAGNOSIS CODE INVALID FORMAT	1155	The Ninth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
360	ADMITTING DIAGNOSIS MISSING	60	Admit Diagnosis is missing or invalid.	16	Claim/service lacks information or has	MA65	Missing/incomplete/invalid admitting
					submission/billing error(s). Usage: Do not		diagnosis.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					1		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
361	ADMITTING DIAGNOSIS CODE INVALID	1147	Admit Diagnosis Code is invalid.	16	Claim/service lacks information or has	MA65	Missing/incomplete/invalid admitting
					submission/billing error(s). Usage: Do not		diagnosis.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
362	EMERGENCY DIAGNOSIS CODE IS INVALID	362	Emergency diagnosis code is invalid.	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
					service reported.		condition.
364	PRINCIPAL ICD PROCEDURE DATE	1301	The Principal ICD Procedure date is	16	Claim/service lacks information or has	N303	Missing/incomplete/invalid principal
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					1		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
365	PRINCIPAL ICD PROCEDURE DATE INVALID	1301	The Principal ICD Procedure date is	16	Claim/service lacks information or has	N303	Missing/incomplete/invalid principal
			missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date.
			-		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					-		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
	•		•	•	•		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
367	1ST OTHER ICD PROCEDURE DATE MISSING	1302	The 1st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
368	1ST OTHER ICD PROCEDURE DATE INVALID	1302	The 1st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
370	2ND OTHER ICD PROCEDURE DATE MISSING	1303	The 2nd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
371	2ND OTHER ICD PROCEDURE DATE INVALID	1303	The 2nd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
373	3RD OTHER ICD PROCEDURE DATE MISSING	1304	The 3rd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
374	3RD OTHER ICD PROCEDURE DATE INVALID	1304	The 3rd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
376	4TH OTHER ICD PROCEDURE DATE MISSING	1305	The 4th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
377	4TH OTHER ICD PROCEDURE DATE INVALID	1305	The 4th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
!	5TH OTHER ICD PROCEDURE DATE	1306	The 5th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
(l	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
ı					use this code for claims		
ı					attachment(s)/other documentation. At		
ı					least one Remark Code must be provided		
ı					(may be comprised of either the NCPDP		
ı					Reject Reason Code, or Remittance Advice		
ı					Remark Code that is not an ALERT.) Refer		
ı					to the 835 Healthcare Policy Identification		
ı					Segment (loop 2110 Service Payment		
					Information REF), if present.		
	5TH OTHER ICD PROCEDURE DATE	1306	The 5th Other ICD Procedure date is	16		N302	Missing/incomplete/invalid other
ı	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
ı					use this code for claims		
ı					attachment(s)/other documentation. At		
ı					least one Remark Code must be provided		
ı					(may be comprised of either the NCPDP		
l					Reject Reason Code, or Remittance Advice		
l					Remark Code that is not an ALERT.) Refer		
l					to the 835 Healthcare Policy Identification		
l					Segment (loop 2110 Service Payment		
ĺ					Information REF), if present.		
381	ATTENDING NPI REQUIRED	1390	The attending physician number is missing	16		N253	Missing/incomplete/invalid attending
l			or invalid. Enter or verify the attending		submission/billing error(s). Usage: Do not		provider primary identifier.
ı			physician's 10-digit NPI number.		use this code for claims		
ı					attachment(s)/other documentation. At		
ı					least one Remark Code must be provided		
ı					(may be comprised of either the NCPDP		
l					Reject Reason Code, or Remittance Advice		
l					Remark Code that is not an ALERT.) Refer		
l					to the 835 Healthcare Policy Identification		
l					Segment (loop 2110 Service Payment		
					Information REF), if present.		
	ATTENDING PROVIDER ID IS INVALID -	1390	The attending physician number is missing	16		N253	Missing/incomplete/invalid attending
	HDR		or invalid. Enter or verify the attending		submission/billing error(s). Usage: Do not		provider primary identifier.
l			physician's 10-digit NPI number.		use this code for claims		
					attachment(s)/other documentation. At		
l					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
1					to the 835 Healthcare Policy Identification		
		1			Segment (loop 2110 Service Payment		
					Information REF), if present.		
			l .				
		1075	N. M. J. S. J. G. O. J. AMB:	200	10 11 11 11	Naca	
383	OTHER 1 PROVIDER ID INVALID - HDR	1975	No Match Found for Other 1 NPI	208	National Provider Identifier - Not matched.	N262	Missing/incomplete/invalid operating provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
395	HEADER STATEMENT COVERS PERIOD FDOS MISSING	389	Header From Date of Service is required. Enter the From Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
396	HEADER STATEMENT COVERS PERIOD FDOS INVALID	1334	Header From Date of Service is invalid. Correct the From Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
397	HEADER STMT COVERS PERIOD TDOS MISSING	1336	Header To Date of Service is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
398	STATEMENT COVERS PERIOD TDOS INVALID	1335	Header To Date of Service is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	1830	The units of service are missing or invalid. Enter/Correct the units of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
405	STH OCCURRENCE CODE INVALID	4085	Sth Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
406	6TH OCCURRENCE CODE INVALID	4086	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
407	7TH OCCURRENCE CODE INVALID	4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
408	8TH OCCURRENCE CODE INVALID	4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
409	1ST OCCURRENCE SPAN CODE INVALID	212	The 1st Occurrence Span Code Invalid. Correct the first occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
410	2ND OCCURRENCE SPAN CODE INVALID	193	The 2nd Occurrence Span code is invalid. Correct the 2nd occurrence span code.Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
411	5TH OCCURRENCE CODE DATE MISSING	734	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
412	STH OCCURRENCE CODE DATE INVALID	734	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
413	6TH OCCURRENCE CODE DATE MISSING	735	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
414	6TH OCCURRENCE CODE DATE INVALID	735	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
415	7TH OCCURRENCE CODE DATE MISSING	4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
416	7TH OCCURRENCE CODE DATE INVALID	4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (Ioop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
417	8TH OCCURRENCE CODE DATE MISSING	4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
418	8TH OCCURRENCE CODE DATE INVALID	4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
419	FDOS FOR 1ST OCCUR SPAN CODE MISSING	1446	The From Date of Service for the First Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
420	FDOS FOR 1ST OCCUR SPAN CODE	1445	The From Date of Service for the First	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
	INVALID		Occurrence Span Code is invalid.		submission/billing error(s). Usage: Do not		date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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104	77.05 FOR 45T 0.05 VR 57.44 0.05 F	4.450					
421	TDOS FOR 1ST OCCUR SPAN CODE	1450	The To Date of Service for the First	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
	MISSING		Occurrence Span Code is required.		submission/billing error(s). Usage: Do not		date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
422	TDOS FOR 1ST OCCUR SPAN CODE	1449	The To Date of Service for the First	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
	INVALID		Occurrence Span Code is invalid.		submission/billing error(s). Usage: Do not		date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
423	FDOS FOR 2ND OCCUR SPAN CODE	1448	The From Date of Service for the Second	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
423	MISSING	1440	Occurrence Span Code is required.	10	submission/billing error(s). Usage: Do not	INZ 33	date(s).
	INITEDING		occurrence span code is required.				uate(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
424	FDOS FOR 2ND OCCUR SPAN CODE	1447	The From Date of Service for the Second	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
	INVALID		Occurrence Span Code is invalid.		submission/billing error(s). Usage: Do not		date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
425	TDOS FOR 2ND OCCUR SPAN CODE	1452	The To Date of Service for the Second	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
423	MISSING	1432	Occurrence Span Code is required.	10	submission/billing error(s). Usage: Do not	INZJJ	date(s).
	IVIISSIIVO		occurrence span code is required.		use this code for claims		uate(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
426	TDOS FOR 2ND OCCUR SPAN CODE	1451	The To Date of Service for the Second	16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence
	INVALID		Occurrence Span Code is invalid.		submission/billing error(s). Usage: Do not		date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
434	MEDICARE COINSURANCE AMOUNT	1230	The Medicare copayment amount is	16	Claim/service lacks information or has	N58	Missing/incomplete/invalid patient
	INVALID		invalid.		submission/billing error(s). Usage: Do not		liability amount.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					<i>"</i> .		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
450	INVALID AREA OF ORAL CAVITY	1136	The Area of the Oral Cavity is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N346	Missing/incomplete/invalid oral cavity designation code.
451	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	452	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
452	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	452	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
458	DIAGNOSIS CODE 10-25 INVALID FORMAT		in positions 10 through 25.	146	service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
459	DETAIL DIAGNOSIS TREATMENT INDICATOR INVALID	596	The diagnosis indicator is missing or invalid. Enter/Correct the diagnosis indicator. Refer to the Provider Manual or Help Screens for valid indicators	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
461	1ST VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
462	1ST VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
463	1ST VALUE CODE AMOUNT IS MISSING	4091	The 1st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
464	9TH OCCURRENCE CODE INVALID	738	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
465	9TH OCCURRENCE CODE DATE MISSING	738	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (Ioop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
466	9TH OCCURRENCE CODE DATE INVALID	738	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
467	OCCURRENCE SPAN CODE 3-24 INVALID	1441	One or more Occurrence Span Code(s) is invalid in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
468	FDOS FOR SPAN CODE 3-24 MISSING	1443	One or more From Date(s) of Service is missing for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
469	FDOS FOR SPAN CODE 3-24 INVALID	1135	One or more From Date(s) of Service is invalid for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
470	TDOS FOR SPAN CODE 3-24 MISSING	1444	One or more To Date(s) of Service is missing for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
471	CONDITION CODE 8-24 INVALID	1130	One or more Condition Code(s) is invalid in positions eight through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
472	TDOS FOR SPAN CODE 3-24 INVALID	1420	One or more To Date(s) of Service is invalid for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
474	6TH OTHER ICD PROCEDURE DATE	1307	The 6th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					,, ,		
		1					
475	6TH OTHER ICD PROCEDURE DATE	1307	The 6th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
478	2ND VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					miomacion nei ,, n presenti		
479	3RD VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claims/sources looks information	M49	Missing/inservalete/invalid value d-/-)
4/9	SKD VALUE CODE IS INVALID	113/	value code is invalid.	10	Claim/service lacks information or has	IVI49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
480	4TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
481	STH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
482	6TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
484	7TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
485	8TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
486	9TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
487	10TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
488	11TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
489	12TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		. ,
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					miorination ner y, ii presenti		
490	2ND VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					, .		
491	3RD VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
491	SRD VALUE CODE AMOUNT IS INVALID	1130	value code amount is invalid.	10	*	10149	
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
492	4TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		-1-7
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information NET J, II present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
493	STH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
494	6TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
495	7TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
496	8TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
497	9TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
498	10TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
499	11TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
501	12TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
504	2ND VALUE CODE AMOUNT IS MISSING	4092	The 2nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
506	DATE BILLED AFTER ICN DATE	1156	Billed date is greater than batch date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
507	DTL FDOS IS AFTER THE DTL TDOS	1462	The detail From Date of Service is after the detail To Date of Service. The From Date of Service must be before the last date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
508	HDR BILLED AMT NOT EQUAL TO DTL BILLED AMT SUM	1330	The total claim charge is omitted or out of balance. Re-calculate and correct the total claim charge.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
510	1ST OCCURRENCE SPAN FDOS IS AFTER TDOS	1383	The first occurrence span from date of service is after the to date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M46	Missing/incomplete/invalid occurrence span code(s).
511	2ND OCCURRENCE SPAN FDOS IS AFTER TDOS	1384	The second occurrence span from date of service is after to to date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.] Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
514	HEADER TDOS AFTER ICN DATE	1457	Header To Date of Service is after the ICN date. The claim was received before the service was rendered. Services must be rendered before claims are submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
515	HEADER FDOS AFTER ICN DATE	1139	Header From Date of Service is after the date of receipt of the claim. The claim was received before the service was rendered.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
516	3RD VALUE CODE AMOUNT IS MISSING	4093	The 3rd value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KET), it present.		
517	4TH VALUE CODE AMOUNT IS MISSING	4094		16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					, .		
519	ADMIT DATE GREATER THAN HEADER	1730	The Admission Date is after the From Date	16	Claim/service lacks information or has	MA40	Missing/incomplete/invalid admission
519	FDOS	1/30		10		IVIA40	
	FDOS		of Service. The Admission Date cannot be		submission/billing error(s). Usage: Do not		date.
			after the From Date. Correct the		use this code for claims		
			Admission/From Date		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
520	5TH VALUE CODE AMOUNT IS MISSING	4095	The 5th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
]					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
521	6TH VALUE CODE AMOUNT IS MISSING	4096	The 6th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
522	7TH VALUE CODE AMOUNT IS MISSING	4097	The 7th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
523	8TH VALUE CODE AMOUNT IS MISSING	4098	The 8th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
524	9TH VALUE CODE AMOUNT IS MISSING	4099	The 9th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
525	10TH VALUE CODE AMOUNT IS MISSING	4101	The 10th value code or amount is missing.		Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KET), it present.		
526	HDR FDOS IS AFTER HDR TDOS	1183	Header From Date of Service is after the	16	Claim/service lacks information or has	M52	Missing/incomplete/invalid from date(s)
			Header To Date of Service. The from date		submission/billing error(s). Usage: Do not		of service.
			of service must be before the last date of		use this code for claims		
			service.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
527	DETAIL FDOS IS AFTER ICN DATE	56	Detail From Date of Service is after the	16	Claim/service lacks information or has	M59	Missing/incomplete/invalid to date(s) of
327	DETAIL FDOS IS AFTER ICN DATE	30	ICN Date. The claim was received before	10	submission/billing error(s). Usage: Do not	IVISS	service.
			the service was rendered. Services must		use this code for claims		service.
			be rendered before claims are submitted.				
			be rendered before claims are submitted.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
528	DTL FDOS TDOS BILLED IN ERROR	4360	The detail date of service is missing or	16	Claim/service lacks information or has	M59	Missing/incomplete/invalid to date(s) of
			invalid. Enter/Correct the detail date of		submission/billing error(s). Usage: Do not		service.
			service. The detail dates of service must		use this code for claims		
			fall within the header dates of service.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
531	11TH VALUE CODE AMOUNT IS MISSING	4102	The 11th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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532	12TH VALUE CODE AMOUNT IS MISSING	4103	The 12th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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533	10TH OCCURRENCE CODE INVALID	739	10th Occurrence Code/Date invalid or	16	Claim/service lacks information or has	M45	Missing/incomplete/invalid occurrence
555	101H OCCORRENCE CODE INVALID	739	· ·	10		IVI45	
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		code(s).
			UB04 Provider Manual or Help Screens for valid codes.		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
534	11TH OCCURRENCE CODE INVALID	740	11th Occurrence Code/Date invalid or	16	Claim/service lacks information or has	M45	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		code(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
			1		least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					miorination KErj, ii present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
535	12TH OCCURRENCE CODE INVALID	741	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
537	13TH OCCURRENCE CODE INVALID	742	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
538	14TH OCCURRENCE CODE INVALID	743	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
539	15TH OCCURRENCE CODE INVALID	744	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
540	16TH OCCURRENCE CODE INVALID	745	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
541	17TH OCCURRENCE CODE INVALID	746	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
542	18TH OCCURRENCE CODE INVALID	747	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
543	19TH OCCURRENCE CODE INVALID	748	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
544	20TH OCCURRENCE CODE INVALID	749	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
546	INVALID ADJUSTMENT CLIENTS MEDICAID ID NOT SUBMIT	1665	Unable To Process Your Adjustment Request. Member ID Not Present.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
546	INVALID ADJUSTMENT CLIENTS MEDICAID ID NOT SUBMIT	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
547	INVALID ADJUSTMENT - FINANCIAL PAYER NOT PRESENT	1666	Unable To Process Your Adjustment Request. Financial Payer Not Indicated.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
547	INVALID ADJUSTMENT - FINANCIAL PAYER	4103	The 12th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
	NOT PRESENT		Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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548	INVALID ADJUSTMENT PROVIDER ID NOT	1667		16		N152	Missing/incomplete/invalid replacement
	PRESENT		Request. Provider ID Not Present.		submission/billing error(s). Usage: Do not		claim information.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
548	INVALID ADJUSTMENT PROVIDER ID NOT	4103	The 12th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
	PRESENT		Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		· · · · · · · · · · · · · · · · ·
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
549	INVALID ADJUSTMENT TCN NOT FOUND	2430		16		N152	Missing/incomplete/invalid replacement
			Enter/Correct the TCN of the original		submission/billing error(s). Usage: Do not		claim information.
			claim to be credited.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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550	DENY INVALID ADJUSTMENTS PRIOR TO	115	Unable To Process Your Adjustment	39	Services denied at the time		
550	DENY INVALID ADJUSTMENTS PRIOR TO CLAIMS ENGINE	115	Unable To Process Your Adjustment Request.	39	Services denied at the time authorization/pre-certification was		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
551	MANUALLY PRICED/PAD CLAIM CANNOT BE ADJUSTED	551	Claim cannot be adjusted - Original claim was manually priced or contained a PAD detail. Void claim and resubmit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
552	INVALID ADJUSTMENT CLIENT NOT FOUND	1670	Unable To Process Your Adjustment Request. Member Not Found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
552	INVALID ADJUSTMENT CLIENT NOT FOUND	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
553	INVALID ADJUSTMENT PROVIDER NOT FOUND	1671	Unable To Process Your Adjustment Request. Provider Not Found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
561	INVALID ADJUSTMENT CLAIM HAS AN OPEN TPL AR	1675	Unable To Process Your Adjustment Request. This Claim Is In Post Pay Billing For Third Party Liability Payment.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
562	INVALID ADJUSTMENT HIST REGION ADJUST NOT ALLOWED	1676	Unable To Process Your Adjustment Request. Claim Can No Longer Be Adjusted. Contact Provider Services For Further Information.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
563	INVALID ADJUSTMENT CLAIM TYPES DO NOT MATCH	1677	Unable To Process Your Adjustment Request. The Claim Type Of The Adjustment Does Not Match The Claim Type Of The Original Claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
564	INVALID ADJUSTMENT CLIENT IDS DO NOT MATCH	1678	Unable To Process Your Adjustment Request. Member ID Number On The Claim And On The Adjustment Request Do Not Match.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
566	INVALID ADJUSTMENT PROVIDERS DO NOT MATCH	1679	Unable To Process Your Adjustment Request. Provider NPI Number and/or the Provider Service Location on the original claim and on the adjustment request do not match.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
567	NON-COV DAYS NOT EQ SUM UNITS W/NON-COV ACCOM CHG	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
568	ADMIT DATE GREATER THAN HEADER DISCHARGE DATE	1393	Discharge Date is before the Admission Date. The discharge date cannot be before the admission date. Correct the discharge/admission date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N50	Missing/incomplete/invalid discharge information.
570	HEADER TOTAL DAYS NOT EQUAL TO DAYS BILLED	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
571	PRIMARY SURGICAL PROCEDURE CODE MISSING	1981	The Principal ICD Procedure code is missing or invalid. Correct the code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.
572	ACCOMM UNITS NOT EQUAL TO HDR DATE RANGE	1260	The sum of the Accommodation Days is not equal to the Header date span.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
573	COVERED DAYS CONFLICT WITH HDR FDOS AND TDOS	3033	Inpatient Units/Covered/Non-Covered Days Conflict	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
574	DOS ARE NOT IN SAME MONTH-HEADER OR DTL	4350	The dates of service span the end of the month. Claim must be split by month.	267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N62	Dates of service span multiple rate periods. Resubmit separate claims.
576	CLAIM HAS THIRD-PARTY PAYMENT-NO CARRIER ON FILE	14	DISCREPANCY EXISTS BETWEEN OTHER COVERAGE CODE AND THE OTHER PAYER PAID AMOUNT.	22	This care may be covered by another payer per coordination of benefits.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
577	SERV DATES ARE NOT IN SAME MONTH- DETAIL	4350	The dates of service span the end of the month. Claim must be split by month.	267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N62	Dates of service span multiple rate periods. Resubmit separate claims.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
578	21ST OCCURRENCE CODE INVALID	750	21st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
579	22ND OCCURRENCE CODE INVALID	751	22nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
580	23RD OCCURRENCE CODE INVALID	752	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
582	24TH OCCURRENCE CODE INVALID	753	24th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
583	10TH OCCURRENCE CODE DATE MISSING	739	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
584	11TH OCCURRENCE CODE DATE MISSING	740	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
588	12TH OCCURRENCE CODE DATE MISSING		12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
589	SUSPEND ADJUSTMENT FOR PRE- PAYMENT VERIFICATION	1854	1st Cycle Mass Adjustment	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
590	13TH OCCURRENCE CODE DATE MISSING	742	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP	M45	Missing/incomplete/invalid occurrence code(s).
					Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refa- to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
591	14TH OCCURRENCE CODE DATE MISSING	743	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
593	15TH OCCURRENCE CODE DATE MISSING	744	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
594	16TH OCCURRENCE CODE DATE MISSING	745	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
595	EXCP CLAIMS SUSPEND FOR REVIEW	167	Required Documentation Has Not Been Submitted.	163	Attachment/other documentation referenced on the claim was not received.	N223	Missing documentation of benefit to the patient during initial treatment period.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
595	EXCP CLAIMS SUSPEND FOR REVIEW	1000	Service Requires Special Review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		
597	17TH OCCURRENCE CODE DATE MISSING	746	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
603	ATTACHMENT INDICATED BUT NOT YET RECEIVED	603	ATTACHMENT WAS INDICATED BUT NOT YET RECEIVED. Attachments must be submitted within 35 days of claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
603	ATTACHMENT INDICATED BUT NOT YET RECEIVED	989	Claim Denied. Attachment was not received within 35 days of a claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
604	18TH OCCURRENCE CODE DATE MISSING	747	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
605	FROM DATE IS AFTER TO DATE FOR SPAN OCC. 3-24	605	From Date of Service is after To Date of Service for one or more occurrence spans 3-24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
607	ATTACHMENT INDICATED BUT NOT YET RECEIVED-INSTIT	607	ATTACHMENT WAS INDICATED BUT NOT YET RECEIVED. Attachments must be submitted within 35 days of claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
607	ATTACHMENT INDICATED BUT NOT YET	989	Claim Denied. Attachment was not	163	Attachment/other documentation		
	RECEIVED-INSTIT		received within 35 days of a claim receipt.		referenced on the claim was not received.		
608	ATTACHMENT INDICATED BUT NOT	989	Claim Denied. Attachment was not	163	Attachment/other documentation		
008	RECEIVED- DENY	363	received within 35 days of a claim receipt.	103	referenced on the claim was not received.		
			, , , , , , , , , , , , , , , , , , , ,				
610	19TH OCCURRENCE CODE DATE MISSING	748	19th Occurrence Code/Date invalid or	16	Claim/service lacks information or has	M45	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		code(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
611	20TH OCCURRENCE CODE DATE MISSING	749	20th Occurrence Code/Date invalid or	16		M45	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for		submission/billing error(s). Usage: Do not		code(s).
			valid codes.		use this code for claims attachment(s)/other documentation. At		
			valid codes.		least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
612	21ST OCCURRENCE CODE DATE MISSING	750	21st Occurrence Code/Date invalid or	16	Claim/service lacks information or has	M45	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		code(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					, , , , , , , , , , , , , , , , , , ,		
613	22ND OCCURRENCE CODE DATE MISSING	751	22nd Occurrence Code/Date invalid or	16	1	M45	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		code(s).
			UB04 Provider Manual or Help Screens for valid codes.		use this code for claims attachment(s)/other documentation. At		
			valia coues.		least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
614	23RD OCCURRENCE CODE DATE MISSING	752	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
615	24TH OCCURRENCE CODE DATE MISSING	753	24th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
616	10TH OCCURRENCE CODE DATE INVALID	739	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
617	11TH OCCURRENCE CODE DATE INVALID	740	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
618	12TH OCCURRENCE CODE DATE INVALID	741	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
619	13TH OCCURRENCE CODE DATE INVALID	742	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
620	14TH OCCURRENCE CODE DATE INVALID	743	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
621	15TH OCCURRENCE CODE DATE INVALID	744	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
622	16TH OCCURRENCE CODE DATE INVALID	745	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
623	17TH OCCURRENCE CODE DATE INVALID	746	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.] Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
624	18TH OCCURRENCE CODE DATE INVALID	747	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UBO4 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
625	19TH OCCURRENCE CODE DATE INVALID	748	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
626	20TH OCCURRENCE CODE DATE INVALID	749	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
627	21ST OCCURRENCE CODE DATE INVALID	750	21st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
628	22ND OCCURRENCE CODE DATE INVALID	751	22nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
629	23RD OCCURRENCE CODE DATE INVALID	752	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
630	24TH OCCURRENCE CODE DATE INVALID	753	24th Occurrence Code/Date invalid or	16	Claim/service lacks information or has	M45	Missing/incomplete/invalid occurrence
			missing. Correct Code/Date. Refer to the		submission/billing error(s). Usage: Do not		code(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KET J, it present.		
504		4000		46			
631	7TH OTHER ICD PROCEDURE DATE	1308	The 7th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
632	8TH OTHER ICD PROCEDURE DATE	1309	The 8th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		ľ
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information KEF), ii present.		
500	OTH OTHER ION BROOKS UP BA	1010	The state of the s	4.5			
633	9TH OTHER ICD PROCEDURE DATE	1310	The 9th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
634	10TH OTHER ICD PROCEDURE DATE MISSING	1311	The 10th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
635	11TH OTHER ICD PROCEDURE DATE MISSING	1312	The 11th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
636	12TH OTHER ICD PROCEDURE DATE MISSING	1313	The 12th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
637	13TH OTHER ICD PROCEDURE DATE MISSING	1314	The 13th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
638	14TH OTHER ICD PROCEDURE DATE MISSING	1315	The 14th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
639	15TH OTHER ICD PROCEDURE DATE MISSING	1316	The 15th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
644	16TH OTHER ICD PROCEDURE DATE MISSING	1317	The 16th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
645	17TH OTHER ICD PROCEDURE DATE MISSING	1318	The 17th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR CODE	ERROR CODE DESCRIPTION	EOB CODE	EOB CODE DESCRIPTION	REASON CODE	REASON CODE DESCRIPTION	REMARK CODE	REMARK CODE DESCRIPTION
646	18TH OTHER ICD PROCEDURE DATE MISSING	1319	The 18th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
647	19TH OTHER ICD PROCEDURE DATE MISSING	1320	The 19th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
648	20TH OTHER ICD PROCEDURE DATE MISSING	1321	The 20th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
649	21ST OTHER ICD PROCEDURE DATE MISSING	1322	The 21st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
650	22ND OTHER ICD PROCEDURE DATE	1323	The 22nd Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
651	23RD OTHER ICD PROCEDURE DATE	1324	The 23rd Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
031	MISSING	1327	missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not	11302	procedure date(s).
	Wilson		missing of mivana. correct the date.		use this code for claims		procedure date(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information KEF), it present.		
653	24TH OTHER ICD PROCEDURE DATE	1325	The 24th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	MISSING		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
654	7TH OTHER ICD PROCEDURE DATE	1308	The 7th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
655	8TH OTHER ICD PROCEDURE DATE	1309	The 8th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
656	9TH OTHER ICD PROCEDURE DATE	1310	The 9th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
657	10TH OTHER ICD PROCEDURE DATE	1311	The 10th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
037	INVALID	1311	missing or invalid. Correct the date.	10	submission/billing error(s). Usage: Do not	11/302	procedure date(s).
	IIVALID		missing of myand. Correct the date.		use this code for claims		procedure date(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
CEO	MATH OTHER ICO PROCEDURE 5 175	1312	The 44th Other ICD December 1	4.5	Claim from its lasts information	Naga	Adia-in-disease land linearity add
658	11TH OTHER ICD PROCEDURE DATE	1312	The 11th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided (may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					momation ner ,, ii present.		
l	1	1	1	1	1	1	l .

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
659	12TH OTHER ICD PROCEDURE DATE INVALID	1313	The 12th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
660	13TH OTHER ICD PROCEDURE DATE INVALID	1314	The 13th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
661	14TH OTHER ICD PROCEDURE DATE INVALID	1315	The 14th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
662	15TH OTHER ICD PROCEDURE DATE INVALID	1316	The 15th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR CODE	ERROR CODE DESCRIPTION	EOB CODE	EOB CODE DESCRIPTION	REASON CODE	REASON CODE DESCRIPTION	REMARK CODE	REMARK CODE DESCRIPTION
663	16TH OTHER ICD PROCEDURE DATE INVALID	1317	The 16th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
664	17TH OTHER ICD PROCEDURE DATE INVALID	1318	The 17th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
665	18TH OTHER ICD PROCEDURE DATE INVALID	1319	The 18th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
666	19TH OTHER ICD PROCEDURE DATE INVALID	1320	The 19th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
667	20TH OTHER ICD PROCEDURE DATE	1321	The 20th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
668	21ST OTHER ICD PROCEDURE DATE	1322	The 21st Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID	1322	missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
	TO THE STATE OF TH		missing of mivana. correct the date.		use this code for claims		procedure dute(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information (E1), it present.		
669	22ND OTHER ICD PROCEDURE DATE	1323	The 22nd Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
670	23RD OTHER ICD PROCEDURE DATE	1324	The 23rd Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
671	24TH OTHER ICD PROCEDURE DATE	1325	The 24th Other ICD Procedure date is	16	Claim/service lacks information or has	N302	Missing/incomplete/invalid other
	INVALID		missing or invalid. Correct the date.		submission/billing error(s). Usage: Do not		procedure date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
674	PROCEDURE CODE CANNOT SPAN DATES	674	Daniel and the second second	16		N63	Debill and in a second date line
6/4	PROCEDURE CODE CANNOT SPAN DATES	674	Procedure cannot span dates of service.	16	Claim/service lacks information or has	Nb3	Rebill services on separate claim lines.
			Procedure must be billed on a single date		submission/billing error(s). Usage: Do not		
			of service		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
676	DOS EXCEEDS TIMELY FILING LIMIT	841	The timely filing deadline was exceeded.	29	The time limit for filing has expired.		
	The service of the se	0.44		20	T		
677	TIMELY FILING LIMIT EXCEEDED	841	The timely filing deadline was exceeded.	29	The time limit for filing has expired.		
679	THIS SERVICE IS NOT COVERED UNDER	679	This service is not covered under	96	Non-covered charge(s). At least one	N428	Not covered when performed in this place
	TELEHEALTH		Telehealth		Remark Code must be provided (may be		of service.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
686	DOS EXCEEDS TIMELY FILING LIMIT	841	The timely filing deadline was exceeded.	29	The time limit for filing has expired.		
687	PAYMENT DATE EXCEEDS TIMELY FILING	830	Payment Date Exceeds Timely Filing	29	The time limit for filing has expired.		
					- '		
701	CHIRO AND POD SERV LIMITED TO QMB	701	Chiropractic and Podiatry Services are	96	Non-covered charge(s). At least one	N30	Patient ineligible for this service.
	AND EPSDT RECIP		limited to QMB and EPSDT recipients.		Remark Code must be provided (may be		
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
702	MEMBER AGE RESTRICTION	1121	Member does not meet the age	6	The procedure/revenue code is	N129	Not eligible due to the patients age.
			restriction for this Procedure Code.	ľ	inconsistent with the patients age. Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					ayment information kerj, ii present.		
L	1	l	1	l	I.		<u> </u>

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
703	BILLING PERIOD EXCEEDS 90 DAYS	703	Billing Period exceeds 90 days	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
704	PAYMENT REQUEST EXCEEDS 31-DAY BILLING LIMIT	704	Payment Request exceeds 31-day billing limit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
706	COVERAGE LIMITED TO PREGNANT ADULTS	706	Coverage is limited to pregnant adults.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
707	COVERAGE LIMITED TO MEDICAID COVERED SERVICE	707	Coverage Limited to Medicaid Covered Service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
708	HCPCS PROCEDURE REQUIRES A VALID NDC	39	The National Drug Code (NDC) is missing or invalid. The NDC is required for physician- administered drugs.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
709	PROVIDER TYPE/SPECIALTY IS NOT ALLOWED TO BILL NDC	709	Provider Type/Specialty is not allowed to bill NDC.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
710	13TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
711	14TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
712	15TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
713	16TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
714	17TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
715	18TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
716	19TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
717	20TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
718	21ST VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					,,,, p. 555		
719	22ND VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
720	23RD VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
720	23ND VALUE CODE IS INVALID	1137	value code is ilivalid.	10	submission/billing error(s). Usage: Do not	IVI43	or amount(s).
					use this code for claims		or amount(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment Information REF), if present.		
					information KErj, ii present.		
721	24TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
					submission/billing error(s). Usage: Do not		or amount(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
723	13TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
724	14TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
725	15TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
726	16TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
727	17TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
728	18TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
729	19TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
730	20TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
731	21ST VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
732	22ND VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
733	23RD VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
734	24TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
735	13TH VALUE CODE AMOUNT IS MISSING	4104	The 13th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
736	14TH VALUE CODE AMOUNT IS MISSING	4105	The 14th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
737	15TH VALUE CODE AMOUNT IS MISSING	4106	The 15th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
738	16TH VALUE CODE AMOUNT IS MISSING	4107	The 16th value code or amount is missing.	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
			Enter the value code/amount. Refer to the		submission/billing error(s). Usage: Do not		or amount(s).
			UB04 Provider Manual or Help Screens for		use this code for claims		
			valid codes.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
739	17TH VALUE CODE AMOUNT IS MISSING	4108	The 17th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.		Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
740	18TH VALUE CODE AMOUNT IS MISSING	4109	The 18th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
741	19TH VALUE CODE AMOUNT IS MISSING	4111	The 19th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
742	20TH VALUE CODE AMOUNT IS MISSING	4112	The 20th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.		Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
743	21ST VALUE CODE AMOUNT IS MISSING	4113	The 21st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.		Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
744	22ND VALUE CODE AMOUNT IS MISSING	4114	The 22nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
745	23RD VALUE CODE AMOUNT IS MISSING	4115	The 23rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (Ioop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
746	24TH VALUE CODE AMOUNT IS MISSING	4116	The 24th value code or amount is missing. Enter the value code/amount. Refer to the UBO4 Provider Manual or Help Screens for valid codes.		Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
749	EVV SERVICES MUST BE SUBMITTED	1749	NEW EVV CLAIMS MUST COME THROUGH		Claim/service lacks information or has	N152	Missing/incomplete/invalid replacement
	THROUGH AN EVV SYST		AN EVV SYSTEM		submission/billing error(s). Usage: Do not		claim information.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mormation ner y, it presents		
750		7.0	NDC: 1 1 16 N 1 1 1 1 1				-1
758	NDC not payable by Nevada Medicaid	758	NDC is excluded for Nevada Medicaid	96	Non-covered charge(s). At least one Remark Code must be provided (may be	N95	This provider type/provider specialty may not bill this service.
					comprised of either the NCPDP Reject		not bill this service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
759	GENDER RESTRICTION FOR NDC	759	GENDER RESTRICTION FOR NDC	16	Claim/service lacks information or has	MA39	Missing/incomplete/invalid gender.
					submission/billing error(s). Usage: Do not		J
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
760	NDC not payable based on patient age	760	Age Restriction on NDC	96	Non-covered charge(s). At least one	N129	Not eligible due to the patients age.
700	Noe not payable based on patient age	700	Age Restriction on NDC	30	Remark Code must be provided (may be	14125	Two engine due to the patients age.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
802	CLAIM FREQUENCY CODE NOT VALID FOR	802	Claim Frequency Code Is not valid for	16	Claim/service lacks information or has	N152	Missing/incomplete/invalid replacement
	ADJUSTMENTS		adjustments.		submission/billing error(s). Usage: Do not		claim information.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		1
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
809	ADMIT DATE ON OR AFTER ICN DATE	1395	Admission Date is on or after Date of Receipt of Claim. The Admission Date cannot be on or after the Date of Receipt on the Claim. Correct the Admission Date	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.
817	DETAIL TDOS NOT WITHIN HEADER RANGE	3314	Denied. Detail Dates Are Not Within Statement Covered Period.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
819	ADMIT DATE NOT EQUAL TO HEADER FDOS	719	Admission Date does not match Header From Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.
841	OTHER INSURANCE SUSPECT	78	Other Insurance Suspect - Please verify that the Other Insurance information/payments are entered correctly.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N48	Claim information does not agree with information received from other insurance carrier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
851	PRINCIPAL DIAG POA CODE IS MIS/INVALID	578	Principal Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice	N434	Missing/Incomplete/Invalid Present on Admission indicator.
					Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
853	HCPCS - ANNUAL UPDATE - SUSPEND CLAIMS	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
856	Procedure code requires attachment	847	NOT CURRENTLY IN USE FOR EDIT 856 Detailed description of items delivered needs to correspond to the claim.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	849	The date of service on the claim and recipient?s date and time of acceptance/delivery must correspond.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	851	The provider NPI on the claim must correspond with the provider name on the delivery receipt.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
856	Procedure code requires attachment	854	The recipient?s name on the claim must correspond with the recipient?s name on the delivery receipt.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	855	The quantity of dentures/partials billed on the claim must correspond with the quantity on the delivery receipt	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	856	Receipt of Dentures/Partials requires a complete, legible attachment.	163	Attachment/other documentation referenced on the claim was not received.		
886	PRINCIPAL DIAGNOSIS OPPC	3291	THE PRINCIPAL DIAGNOSIS IS A CMS- DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
888	CLAIM FILING VALUE NOT ALLOWED	3029	Claim filing value is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
892	DUPLICATE OTHER PAYER IDENTIFIERS	1002	DUPLICATE OTHER PAYER IDENTIFIERS	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M56	Missing/incomplete/invalid payer identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
893	PAD - PAD REVERSAL IDENTIFIED	897	PAD - Void Request Acknowledged	96	Non-covered charge(s). At least one	N10	Adjustment based on the findings of a
					Remark Code must be provided (may be		review organization/professional
					comprised of either the NCPDP Reject		consult/manual adjudication/medical
					Reason Code, or Remittance Advice		advisor/dental advisor/peer review.
					Remark Code that is not an ALERT.) Usage:		1
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment information KEr), it present.		
894	PAD - PAD REVERSAL IDENTIFIED	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum	N130	Consult plan benefit
					allowable or contracted/legislated fee		documents/guidelines for information
					arrangement. Usage: This adjustment		about restrictions for this service.
					amount cannot equal the total service or		
					claim charge amount; and must not		
					duplicate provider adjustment amounts		
					(payments and contractual reductions)		
					I ** *		
					that have resulted from prior payer(s)		
					adjudication. (Use only with Group Codes		
					PR or CO depending upon liability)		
895	PAD - PBM REVERSAL ERROR	895	PBM Reversal Error	16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s)
033	TAD TOWNEVERSAL ERROR	055	I BIVI NEVEISUI EITOI	10	submission/billing error(s). Usage: Do not	14143	or amount(s).
					use this code for claims		or amount(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
897	PAD - VOID DENIAL	897	PAD - Void Request Acknowledged	96	Non-covered charge(s). At least one	N10	Adjustment based on the findings of a
100.	TO TO DENIAL				Remark Code must be provided (may be		review organization/professional
					· _ · _ · _ · _ · _ · _ · _ · _ ·		
					comprised of either the NCPDP Reject		consult/manual adjudication/medical
					Reason Code, or Remittance Advice		advisor/dental advisor/peer review.
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
000	PAD IDENTIFIED DETAIL	898	Datail is being cont to DDM for militar	142	Dortion of normant deformed		<u> </u>
898	PAD IDENTIFIED DETAIL	030	Detail is being sent to PBM for pricing.	143	Portion of payment deferred.		
899	PAD CLAIMS HELD FOR PBM RESPONSE	899	PAD CLAIMS HELD FOR PBM RESPONSE	133	The disposition of this service line is		
					pending further review. (Use only with		
					Group Code OA). Usage: Use of this code	1	
					requires a reversal and correction when		
					the service line is finalized (use only in		
					Loop 2110 CAS segment of the 835 or		
					Loop 2430 of the 837).		
1			1			1	1

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
900	PROVIDER TYPE SPECIALTY GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
902	PROCEDURE CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
903	DIAGNOSIS CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
906	ICD PROCEDURE CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
906	ICD PROCEDURE CODE GROUP NOT FOUND	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
908	PAD DETAIL DENIED BY PBM	908	PAD detail denied by PBM.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
909	PAD DETAIL NO RESPONSE FROM PBM	909	PAD detail denied - Contact the Pharmacy Benefit Manager.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
910	BENEFIT PLAN GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
911	INTERNAL ERROR	3581	System Error - Parameter Not Found For DOS	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		
912	MODIFIER CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
913	REVENUE CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
914	TOB GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
916	PROVIDER CONTRACT GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
918	AID CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
919	PROVIDER GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
922	DECISION WITH EMPTY FAILED LIST	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
923	ADJUSTMENT REASON CODE GROUP NOT GOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
923	ADJUSTMENT REASON CODE GROUP NOT 9	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
927	PROVIDER TYPE AND SPECIALTY NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
929	MULTIPLE LOC PLANS	929	Multiple Nursing Home Level of Care Segments on Recipient File.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
930	INTERNAL ERROR - COS ASSIGNMENT CALL FAILED	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
931	INTERNAL ERROR - FUND CODE ASSIGNMENT FAILED	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
931	INTERNAL ERROR - FUND CODE ASSIGNMENT FAILED	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
934	CLIA LAB CODE NOT FOUND FOR PROCEDURE CODE	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
941	THE HMO PAID DATE IS INVALID	2401	The HMO Paid Date is invalid. A valid other payer date is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid adjudication or payment date.
943	NEGATIVE ALLOWED AMOUNT	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
944	2ND EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1901	2nd External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
945	3RD EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1902	3rd External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
946	4TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1903	4th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
947	STH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1904	Sth External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
948	6TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1905	6th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
949	7TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1906	7th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
950	8TH EXTERNAL CAUSE OF INJURY	1907	8th External Cause of Injury Code is	16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or
	DIAGNOSIS INVALID		invalid. Correct the external cause of		submission/billing error(s). Usage: Do not		condition.
			injury code.		use this code for claims		
			, ,		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					, , , , , , , , , , , , , , , , , , ,		
951	9TH EXTERNAL CAUSE OF INJURY	1908	9th External Cause of Injury Code is	16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or
	DIAGNOSIS INVALID		invalid. Correct the external cause of		submission/billing error(s). Usage: Do not		condition.
			injury code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
952	10TH EXTERNAL CAUSE OF INJURY	1909	10th External Cause of Injury Code is	16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or
332	DIAGNOSIS INVALID	1303	invalid. Correct the external cause of		submission/billing error(s). Usage: Do not		condition.
	DIAGNOSIS INVALID		injury code.		use this code for claims		condition.
			injury code.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information REF), if present.		
953	11TH EXTERNAL CAUSE OF INJURY	1910	11th External Cause of Injury Code is	16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or
	DIAGNOSIS INVALID		invalid. Correct the external cause of		submission/billing error(s). Usage: Do not		condition.
			injury code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
954	12TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1911	12th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
990	RULES DLL LIBRARY NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
991	RULES VARIABLE LIBRARY NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
992	RULES FUNCTION NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
1000	BILLING PROVIDER I.D. NOT ON FILE	352	The billing provider number is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N255	Missing/incomplete/invalid billing provider taxonomy.
1002	RENDERING PROVIDER NOT ELIGIBLE	1284	Rendering Provider is not certified for the From Date of Service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1003	BILLING PROV NOT ELIG AT SERV LOC ON DTL DOS	3120	The billing provider is not eligible on date(s) of service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
1007	RENDERING PROV NUM/SVC LOCATION NOT ON FILE	1504	Performing Provider number is not found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1008	BILLING PROV IS NOT A GRP/PERFORMING IS A GRP PROV	1508	Billing Provider cannot be an Individual Provider or Servicing Provider cannot be a Group Provider.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N799	Submitted identifier must be an individual identifier, not group identifier.
1009	CONTRACT COULD NOT BE DETERMINED - DTL	1009	A billing provider contract could not be assigned to this claim. Please refer to the provider billing manuals for guidelines about correct billing information and that you are using the correct billing provider ID. Please make sure that the billing provider has been revalidated and that you are using the correct billing provider service location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110	The rendering provider is not a group member. Verify the rendering provider number/group number.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N55	Procedures for billing with group/referring/performing providers were not followed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1011	CONTRACT COULD NOT BE DETERMINED - HDR ATTENDING PROV NOT ENROLLED	1011	A billing provider contract could not be assigned to this claim. Please refer to the provider billing manuals for guidelines about correct billing information and that you are using the correct billing provider ID. Please make sure that the billing provider has been revalidated and that you are using the correct billing provider service location. The attending provider is not enrolled in	283	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Attending provider is not eligible to	N130	Consult plan benefit documents/guidelines for information about restrictions for this service. The Medicaid state requires provider to
1012	ATTENDING PROVINGT ENROLLED	12	any provider contract on the FDOS of the claim, or the provider ID is not valid on the FDOS of the claim.	263	provide direction of care.	11/6/	be enrolled in the members Medicaid state program prior to any claim benefits being processed.
1022	REFERRING NPI REQUIRED	1024	A valid referring provider NPI is required.	208	National Provider Identifier - Not matched.	N286	Missing/incomplete/invalid referring provider primary identifier.
1024	PROVIDER NOT LISTED AS CLIENT LOC PROV	776	The provider is not listed as the recipient's level of care provider or is not listed for these dates of service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N450	Covered only when performed by the primary treating physician or the designee.
1026	HEADER REFERRING PROVIDER NPI INVALID	1345	Submitted referring provider NPI in the header is invalid.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.
1027	REF PROV NPI REQUIRED AND NOT VALID		Submitted referring provider NPI in the detail is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N286	Missing/incomplete/invalid referring provider primary identifier.
1028	REF PROV NOT REQUIRED BUT SUBMITTED AND NOT VALID	718	Referring Provider ID is not required for this service and Referring Provider ID is invalid.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.
1030	NURSING FACILITY NPI REQUIRED - HOSPICE LTC CLAIMS	1030	A Nursing Facility NPI is required for Hospice LTC claims.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
1032	RENDERING NPI INACTIVE	1976	Rendering NPI Inactive	208	National Provider Identifier - Not matched.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1035	NO MATCH FOUND FOR OTHER 1 NPI	1975	No Match Found for Other 1 NPI	208	National Provider Identifier - Not matched.	N262	Missing/incomplete/invalid operating provider primary identifier.
1036	UNIQUE PROV NOT FOUND FOR OTHER 1 NPI	1977	Unique Provider Service Location could not be found for Other 1 NPI - Detail	208	National Provider Identifier - Not matched.	N262	Missing/incomplete/invalid operating provider primary identifier.
1041	NO MATCH FOUND FOR OTHER 2 NPI	1965	No match found for Other 2 NPI	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N262	Missing/incomplete/invalid operating provider primary identifier.
1044	ATTENDING PROV NPI REQUIRED AND NOT VALID	1044	The submitted Attending Provider ID is not a valid NPI.	208	National Provider Identifier - Not matched.	N253	Missing/incomplete/invalid attending provider primary identifier.
1047	PROVIDER TERMINATED - DTL PERFORMING	205	Detail Rendering Provider is no longer enrolled for the Date of Service	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
1048	PROVIDER TERMINATED - DTL DOS	25	Billing or Rendering Provider is no longer enrolled for the From Date of Service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
1051	PERFORMING PROVIDER NOT ON PROVIDER DATABASE	1504	Performing Provider number is not found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1052	OTHER-2 PROVIDER ID - HDR MISSING/NOT VALID	1965	No match found for Other 2 NPI	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N262	Missing/incomplete/invalid operating provider primary identifier.
1062	ORDERING NPI REQUIRED	1062	Ordering NPI is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1063	ORDERING PROVIDER NPI REQUIRED AND NOT VALID	1063	Ordering Provider NPI is required and not valid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1064	ORDERING PROVIDER NPI NOT REQUIRED AND NOT VALID	1064	Ordering Provider NPI was not required and not valid.	208	National Provider Identifier - Not matched.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1070	PROCEDURE MISSING ON OUTPATIENT CLAIM	1464	Procedure Missing On Outpatient Claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
1071	ATTENDING PROV CANNOT BE A GROUP OR ORGANIZATION	1071	Attending Provider cannot be a Group or Organization.	283	Attending provider is not eligible to provide direction of care.	N799	Submitted identifier must be an individual identifier, not group identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1076	PROV CONTRACT NOT VALID ON DOS - DTL	1012	Billing Provider Not Eligible on DOS.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1077	PROV CONTRACT NOT VALID ON DOSHDR	1012	Billing Provider Not Eligible on DOS.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1079	REFERRING PROV CANNOT BE A GROUP OR ORGANIZATION	1360	Referring Provider cannot be a Group Provider	183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N799	Submitted identifier must be an individual identifier, not group identifier.
1082	REFERRING NPI CANNOT BE THE SAME AS SERVICING NPI	92	Referring NPI cannot be the same as the servicing NPI	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N55	Procedures for billing with group/referring/performing providers were not followed.
1548	DATE OF LAST SERVICE GREATER THAN ICN DATE	57	Detail To Date of Service is after the ICN Date. The claim was received before the service was rendered. Services must be rendered before claims are submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
1799	CHARGES SPAN TWO OF PROVIDERS FISCAL YEARS	1655	Charges span two of provider's fiscal years. A split claim is required when the service dates on the claim overlap the provider's fiscal years.	204	This service/equipment/drug is not covered under the patients current benefit plan		
1801	BILLING AND SERVICING PROVIDER ARE DIFFERENT	678	Billing and Servicing provider are different	208	National Provider Identifier - Not matched.		
1802	BILLING PROV NOT ELIGIBLE FOR PARTIAL DOS	720	Billing Provider is not certified for the Date(s) of Service.	242	Services not provided by network/primary care providers.	N95	This provider type/provider specialty may not bill this service.
1803	RENDERING PROV NOT ELIGIBLE FOR PARTIAL DOS	1284	Rendering Provider is not certified for the From Date of Service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1898	ENCOUNTER - PROVIDER NAME MISSING	2415	ENCOUNTER - Provider Name Missing.	206	National Provider Identifier - missing.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1900	TAXONOMY IS INVALID BILLING PROVIDER		The Billing Provider's taxonomy code in	16	Claim/service lacks information or has	N255	Missing/incomplete/invalid billing
	- HDR		the header is invalid.		submission/billing error(s). Usage: Do not		provider taxonomy.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
1906	TAXONOMY IS NOT VALID BILLING PROVIDER - HDR	352	The billing provider number is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not	N255	Missing/incomplete/invalid billing provider taxonomy.
	PROVIDER - HDR						provider taxonomy.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
			1		Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					, ,		
1906	TAXONOMY IS NOT VALID BILLING	1237	The Billing Provider's taxonomy code is	208	National Provider Identifier - Not	N255	Missing/incomplete/invalid billing
1500	PROVIDER - HDR	1237	invalid.	200	matched.	N233	provider taxonomy.
1912	TAXONOMY IS MISSING BILLING	1492	The Billing Provider's taxonomy code is	16	Claim/service lacks information or has	N255	Missing/incomplete/invalid billing
1912	PROVIDER - HDR	1492		10	1 .	N233	
	PROVIDER - HDR		missing.		submission/billing error(s). Usage: Do not		provider taxonomy.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
			1		to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					,, ,		
1927	BILLING HEALTHCARE PROVIDER	1207	A National Provider Identifier (NPI) is	16	Claim/service lacks information or has	N257	Missing/incomplete/invalid billing
	REQUIRES NPI - HDR		required for the Billing Provider.	-	submission/billing error(s). Usage: Do not	-	provider/supplier primary identifier.
	negomes with them		required for the bining riovider.		use this code for claims		provider, supplier primary identifier.
			1		attachment(s)/other documentation. At		
			1				
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
			1		Segment (loop 2110 Service Payment		
		1			Information REF), if present.		
		1					

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1928	NPI REQUIRED HEALTHCARE=Y PERFORMING PROV - HDR	1112	A National Provider Identifier (NPI) is required for the Rendering Provider listed in the header.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1929	NPI REQUIRED HEALTHCARE=Y REFERRING PROV - HDR	1110	A National Provider Identifier (NPI) is required for the Referring Provider listed in the header.	206	National Provider Identifier - missing.	N286	Missing/incomplete/invalid referring provider primary identifier.
1935	NPI REQUIRED HEALTHCARE=Y REFERRING PROV - DTL	1111	A National Provider Identifier (NPI) is required for the Referring Provider listed in the detail.	206	National Provider Identifier - missing.	N286	Missing/incomplete/invalid referring provider primary identifier.
1936	INVALID INTERNAL BILLING PROV ID SPECIFIED - HDR	1207	A National Provider Identifier (NPI) is required for the Billing Provider.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
1937	INVALID INTERNAL RENDERING PROV SPECIFIED - HDR	943	RENDERING PROVIDER IS NOT FOUND. PLEASE MAKE SURE THAT THE RENDERING PROVIDER HAS BEEN REVALIDATED, THAT THE RENDERING PROVIDER IS AFFILIATED WITH YOUR BILLING GROUP AND THAT YOU ARE USING THE CORRECT RENDERING PROVIDER ID.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1938	INVALID REFERRING PROV SPECIFIED - HDR	91	A valid enrolled prescribing/referring/ordering provider NPI is required.	208	National Provider Identifier - Not matched.	N286	Missing/incomplete/invalid referring provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1943	INVALID INTERNAL RENDERING PROV SPECIFIED - DTL	943	RENDERING PROVIDER IS NOT FOUND. PLEASE MAKE SURE THAT THE RENDERING PROVIDER HAS BEEN REVALIDATED, THAT THE RENDERING PROVIDER IS AFFILIATED WITH YOUR BILLING GROUP AND THAT YOU ARE USING THE CORRECT RENDERING PROVIDER ID.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1944	INVALID REFERRING PROV SPECIFIED - DTL	3461	The referring provider number is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N276	Missing/incomplete/invalid other payer referring provider identifier.
1945	MULTI PROV LOCS FOR BILLING PROV SPEC - HDR	1208	Multiple Service Locations Found For the Billing Provider NPI	208	National Provider Identifier - Not matched.	N77	Missing/incomplete/invalid designated provider number.
1946	MULTI PROV LOCS FOR PERFORMING PROV SPEC - HDR	1978	Unique Provider Service Location could not be found for Rendering NPI	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N294	Missing/incomplete/invalid service facility primary address.
1948	MULTI PROV LOCS FOR FACILITY PROV SPEC - HDR	1500	Multiple Service Locations found for Facility Provider NPI.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1950	MULTI PROV LOCS FOR OTHER PROV SPEC - HDR	1501	Multiple Service Locations found for Other Provider NPI.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
1951	MULTI PROV LOCS FOR OTHER PROV SPEC	1502	Multiple Service Locations found for Other Provider NPI - Detail	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
1952	MULTI PROV LOCS FOR RENDERING PROV SPEC - DTL	971	Multiple Service Provider Locations were found for the Rendering Provider. Please verify the rendering provider. For questions, contact Provider Services.	208	National Provider Identifier - Not matched.		
1954	HEADER RENDERING NPI INVALID	1288	Submitted rendering provider NPI in the header is invalid.	208	National Provider Identifier - Not matched.		
1955	DETAIL RENDERING PROVIDER ID INVALID	1375		16		N290	Missing/incomplete/invalid rendering provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1956	NO BILLING PROVIDER LOCATION STATUS FOUND	956	No billing provider location status found for date of service range. Please make sure the billing provider has been revalidated and that you are using the correct provider id.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
1958	NO BILLING PROVIDER LOCATION STATUS FOR DOS RANGE	956	No billing provider location status found for date of service range. Please make sure the billing provider has been revalidated and that you are using the correct provider id.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
1960	NO PROVIDER BILLING INDICATOR FOUND	1960	No Provider Billing Indicator Found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
1961	MORE THAN ONE PROVIDER BILLING INDICATOR	1961	Unable to determine provider's billing status. Please contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1962	NO PROVIDER BILLING INDICATOR FOR DOS RANGE	962	Unable to determine whether a provider is a biller, renderer, or OPR provider for the date of service range. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
1963	RENDERING PROVIDER IS NOT DESIGNATED TO RENDER	175	Rendering Provider indicated is not certified as a rendering provider.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N767	The Medicaid state requires provider to be enrolled in the members Medicaid state program prior to any claim benefits being processed.
1964	BILLING PROVIDER IS NOT DESIGNATED AS	1509	Billing Provider indicated is not certified	243	Services not authorized by network/primary care providers.	N95	This provider type/provider specialty may
1965	A BILLER RENDERING REQUIRED AND RENDERING IS NOT PRESENT	1503	as a billing provider. A Rendering Provider number is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	not bill this service. Missing/incomplete/invalid rendering provider primary identifier.
1966	NO REND PROVIDER LOCATION STATUS FOUND	966	No Rendering Provider Location Status (In/Out of State) information is found. Please verify the rendering provider. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1967	MORE THAN ONE REND PROVIDER	967	Conflicting Rendering Provider Location	16	Claim/service lacks information or has	N258	Missing/incomplete/invalid billing
	LOCATION STATUS		Status (In/Out of State). Please verify the		submission/billing error(s). Usage: Do not		provider/supplier address.
			rendering provider. For questions, contact		use this code for claims		
			Provider Services.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					morniation KET), ii present.		
1968	NO REND PROVIDER LOCATION STATUS FOR DOS RANGE	968	Conflicting Rendering Provider Location	16	Claim/service lacks information or has	N258	Missing/incomplete/invalid billing
	FOR DOS RANGE		Status (In/Out of State). Please verify the		submission/billing error(s). Usage: Do not		provider/supplier address.
			rendering provider. For questions, contact		use this code for claims		
			Provider Services.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
1970	MULTI SVC LOCATIONS - BILLING	970	Multiple Service Provider Locations were	208	National Provider Identifier - Not	N257	Missing/incomplete/invalid billing
	PROVIDER NPI		found for the Billing Provider NPI. Please		matched.		provider/supplier primary identifier.
			verify the billing provider. For questions,				
			contact Provider Services.				
1971	MULTI SVC LOCATIONS - RENDERING	971	Multiple Service Provider Locations were	208	National Provider Identifier - Not		
1371	PROVIDER NPI HDR	2,1	found for the Rendering Provider. Please	200	matched.		
	THO VIDER IN THIS R		verify the rendering provider. For		materieu.		
			questions, contact Provider Services.				
			questions, contact rovider services.				
1972	MULTI SERVICE LOCATIONS FOR FACILITY	972	Multiple Service Provider Locations were	16	Claim/service lacks information or has	N293	Missing/incomplete/invalid service facility
	PROVIDER NPI		found for the Facility Provider NPI. Please		submission/billing error(s). Usage: Do not		primary identifier.
			verify the rendering provider. For		use this code for claims		
			questions, contact Provider Services.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					, ,, ,, ,, ,,		
1973	MULTI SVC LOCATIONS -RENDERING	971	Multiple Service Provider Locations were	208	National Provider Identifier - Not		
13.3	PROVIDER NPI DTL		found for the Rendering Provider. Please	200	matched.		
	THO VIDEN INTI DIE		verify the rendering provider. For		inaccirca.		
			questions, contact Provider Services.				
1974	OPR PROV NOT ENROLLED	30	Prescribing/referring/ordering provider is	207	National Provider identifier - Invalid	N286	Missing/incomplete/invalid referring
			not currently enrolled.		format		provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1975	REF/PRESCRIB PROVIDER RSTCN ON BILLING RULE	975	A valid enrolled prescribing, referring or ordering provider is required to bill this service.	183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N808	Not covered for this provider type / provider specialty.
1976	REF/PRESCRIB PT/PS RSTCN ON BILLING RULE	976	The procedure is not billable with the prescribing/referring or ordering provider's specialty.	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N808	Not covered for this provider type / provider specialty.
1977	OPR PROV NOT ENROLLED	30	Prescribing/referring/ordering provider is not currently enrolled.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.
1981	NPI REQUIRED HEALTHCARE = Y ORDERING PROV-DETAIL	981	A National Provider Identifier (NPI) is required for the Ordering Provider listed in the detail.	206	National Provider Identifier - missing.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1982	INVALID ORDERING PROVIDER - DETAIL	1025	A valid enrolled ordering provider NPI is required.	208	National Provider Identifier - Not matched.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1996	REND PROV ID NOT EFFECTIVE FOR DOS - DTL	205	Detail Rendering Provider is no longer enrolled for the Date of Service	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
1999	BILLING PROV ID NOT EFFECTIVE FOR DOS - HDR	3120	The billing provider is not eligible on date(s) of service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
2001	RECIPIENT ID NUMBER NOT ON FILE	1298	Member ID is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.
2003	CLIENT INELIGIBLE ON DTL DOS	3006	Denied. Member Not Eligibile For All/partial Dates. Please Rebill Only Covered Dates.	31	Patient cannot be identified as our insured.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2012	RECIPIENT BIRTHDATE AFTER FDOS	272	The Admit Date on the claim is prior to the client's Date of Birth. Re-submit claim with an Admit Date equal to or greater than the client's Date of Birth.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
2016	GENDER CONFLICT - UNBORNS	10	Denied. A gender and/or DOB update is required. Recipient must call caseworker to get the information updated first before resubmitting the claim.	7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
2017	CLIENT SERVICES COVERED BY HMO PLAN	38	The member is enrolled in a Medicaid Managed Care Plan. The service requested is covered by the Medicaid Managed Care Plan.	22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.
2027	CLIENT SERVICES COVERED BY DBA PLAN	227	Client Services Covered by DBA Plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
2030	Psychiatric Hospital Inpatient Age Restriction	282	Inpatient psychiatric services are not reimbursable for recipients age 21 - 64 (age 22 if receiving services prior to 21st birthday). Effective 8/1/23: PT 13 instructed to split bill if a revenue code in Revenue Group 2002 is billed with a revenue code not included in the group. If a claim is not split billed (i.e., billed on a separate claim), the entire claim will deny.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
2043	CLIENT ON REVIEW	222	Suspended for recipient review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2054	UNABLE TO DETERMINE CLIENT AID CATEGORY	174	Unable to determine client aid category.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
2057	CLIENT NOT ELIGIBLE ON ALL DATES OF SERVICE-DTL	2710	The client is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
2077	CLIENT NOT ELIGIBLE ON ALL DATES OF SERVICE-HDR	2710	The client is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT, Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
2500	CLIENT COVERED BY MEDICARE A	2590	The client has Medicare. Charges must billed to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits.	22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.
2502	CLIENT COVERED BY MEDICARE B	2590	The client has Medicare. Charges must billed to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits.	22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.
2503	FOUND CARRIER - TPL AMOUNT SUBMITTED	2503	HMS IDENTIFIED CLIENT COVERED BY PRIVATE INSURANCE	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.
2504	CLIENT COVERED BY PRIVATE INSURANCE		Client covered by Private Insurance.Please resubmit claim with appropriate cla im adjustment reason code (CARC).on the claim.		Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
2504	CLIENT COVERED BY PRIVATE INSURANCE	-	,	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.
2509	Client Covered by Private Insurance Original claim	1249	Client Covered by Private Insurance.	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2513	MEDICARE A EXHAUST WITH NO PART B	2513	MEDICARE A EXHAUST WITH NO PART B.	22	This care may be covered by another payer per coordination of benefits.	N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
2531	NO MEDICARE A COVERAGE ON FILE FOR RECIPIENT	2531	Claim suspended for No Medicare Coverage on File for Recipient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
2531	NO MEDICARE A COVERAGE ON FILE FOR RECIPIENT	2533	No Medicare Coverage on File for Recipient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
2532	NO MEDICARE B COVERAGE ON FILE FOR RECIPIENT	2531	Claim suspended for No Medicare Coverage on File for Recipient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
2532	NO MEDICARE B COVERAGE ON FILE FOR RECIPIENT	2533	No Medicare Coverage on File for Recipient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2533	NO MEDICARE COVERAGE ON FILE FOR RECIPIENT	2533	No Medicare Coverage on File for Recipient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Ramark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
2603	LOCK-IN VIOLATION	2730	The client is in the Locked-in program. The Lock-in provider number must be either the billing or rendering number on the claim. For institutional claims, the billing provider must be the lock-in provider.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M62	Missing/incomplete/invalid treatment authorization code.
2801	Medicaid, NCU Benefit plans not billable on same c	2801	Medicaid and Nevada Check-Up Benefit plans may not be billed on the same claim. Please rebill denied details on a separate claim	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.		
3000	UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTH	1526	Services billed exceed PA amount.	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with precertified/authorized services.
3001	PRIOR AUTHORIZATION NOT FOUND	192	Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim.	197	Precertification/authorization/notification/pre-treatment absent.		
3003	PRIOR AUTH IS DENIED	518	There is no valid PA on file for this item. The PA is denied, inactive, or rejected. Submit a PA for this service. When approved, enter the prior authorization number on the claim.	197	Precertification/authorization/notification/pre-treatment absent.		
3004	PRIOR AUTH LINE ITEM STATUS DENY	518	There is no valid PA on file for this item. The PA is denied, inactive, or rejected. Submit a PA for this service. When approved, enter the prior authorization number on the claim.	197	Precertification/authorization/notification/pre-treatment absent.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3006	PA DOLLARS EXCEEDED	1524	Billed amount exceeds PA amount.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre- certified/authorized services.
3008	PRIOR AUTH SERVICE CONFLICT	3008	The prior authorization does not match the services billed on your claim or there are no remaining units available for the line item. Please correct services or submit a new prior authorization for the services billed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre- certified/authorized services.
3009	PARTIAL PA FOUND	399	Date Of Service Must Fall Between The Prior Authorization Start Date and Prior Authorization End Date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with precertified/authorized services.
3014	ALLOWED AMOUNT ZERO WITH PRICING PA	314	Allowed Amount of Zero with Pricing PA.	287	Referral exceeded	N45	Payment based on authorized amount.
3026	MODIFIER DOES NOT MATCH PA	504	There is no PA on file for the procedure with the billed modifier. Check the approved PA and verify the procedure and modifier.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
3030	PROVIDER ID ON CLAIM DOES NOT MATCH PA	4	The provider on this payment request is not the provider on the approved PA.	119	Benefit maximum for this time period or occurrence has been reached.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3032	TOOTH CODE BILLED DOES NOT MATCH PA	505	Tooth Code on claim does not match tooth code on Prior Authorization Request.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre- certified/authorized services.
3033	TOOTH SURFACE BILLED DOES NOT MATCH PA	506	Surface code on claim does not match surface code on Prior Authorization Request.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre- certified/authorized services.
3042	RECIPIENT NUMBER BILLED DOES NOT MATCH PA	2	Recipient ID on claim does not match Recipient ID on Prior Authorization Request.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre- certified/authorized services.
3200	2ND DIAGNOSIS OPPC	3292	THE 1ST OTHER DIAGNOSIS IS A CMS- DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3201	3RD DIAGNOSIS OPPC	3293	THE 2ND OTHER DIAGNOSIS IS A CMS- DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3202	4TH DIAGNOSIS OPPC	3294	THE 3RD OTHER DIAGNOSIS IS A CMS- DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		

ERROR_COD	DE ERROR_CODE_DESCRIPTION	N EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3203	5TH DIAGNOSIS OPPC	3296	THE 4TH OTHER DIAGNOSIS IS A CMS- DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.		Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3204	6TH DIAGNOSIS OPPC	3298	THE 5TH OTHER DIAGNOSIS IS A CMS- DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3205	7TH DIAGNOSIS OPPC	3300	The 6th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3206	8TH DIAGNOSIS OPPC	3302	The7th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3207	9TH DIAGNOSIS OPPC	3304	The 8th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3208	10TH DIAGNOSIS OPPC	3306	The 9th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3209	11TH DIAGNOSIS OPPC	3312	The 10th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3210	12TH DIAGNOSIS OPPC	3318	The 11th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3211	13TH DIAGNOSIS OPPC	3324	The 12th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3212	14TH DIAGNOSIS OPPC	3330	The 13th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3213	15TH DIAGNOSIS OPPC	3336	The 14th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3214	16TH DIAGNOSIS OPPC	3342	The 15th Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3215	17TH DIAGNOSIS OPPC	3348	The 16th Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3216	18TH DIAGNOSIS OPPC	3354	The 17th Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3217	19TH DIAGNOSIS OPPC	3360	The 18th Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3218	20TH DIAGNOSIS OPPC	3366	The 19th Other Diagnosis code	233	Services/charges related to the treatment		
3210	20111 DIAGNOSIS OFFC	3300	(Institutional), 3rd Diagnosis Code	233	of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.		preventable medical errori		
			remisarsement unen an en e is present				
3219	21ST DIAGNOSIS OPPC	3372	The 20th Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3220	22ND DIAGNOSIS OPPC	3378	The 21st Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3221	23RD DIAGNOSIS OPPC	3384	The 22nd Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3222	24TH DIAGNOSIS OPPC	3390	The 23rd Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3223	25TH DIAGNOSIS OPPC	3396	The 24th Other Diagnosis code	233	Services/charges related to the treatment		
			(Institutional), 3rd Diagnosis Code		of a hospital-acquired condition or		
			(Professional) OPPC). CMS does not allow		preventable medical error.		
			reimbursement when an OPPC is present.				
3224	ADMITTING DIAGNOSIS OPPC	3408	The Admitting Diagnosis is a CMS-defined	233	Services/charges related to the treatment		
			Other Provider Preventable Condition		of a hospital-acquired condition or		
			(OPPC). CMS does not allow		preventable medical error.		
1			reimbursement when an OPPC is present.				

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3230	2ND DIAG POA CODE IS MIS/INVALID	3409	1st Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.
3231	3RD DIAG POA CODE IS MIS/INVALID	3410	2nd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.
3232	4TH DIAG POA CODE IS MIS/INVALID	3411	3rd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.
3233	5TH DIAG POA CODE IS MIS/INVALID	3412	4th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3234	6TH DIAG POA CODE IS MIS/INVALID	3413	5th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3235	7TH DIAG POA CODE IS MIS/INVALID	3414	6th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3236	8TH DIAG POA CODE IS MIS/INVALID	3415	7th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3237	9TH DIAG POA CODE IS MIS/INVALID	3416	8th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3238	10TH DIAG POA CODE IS MIS/INVALID	3417	9th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/incomplete/Invalid Present on Admission indicator.
3239	11TH DIAG POA CODE IS MIS/INVALID	3418	10th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3240	12TH DIAG POA CODE IS MIS/INVALID	3419	11th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3241	13TH DIAG POA CODE IS MIS/INVALID	3420	12th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3242	14TH DIAG POA CODE IS MIS/INVALID	3421	13th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3243	15TH DIAG POA CODE IS MIS/INVALID	3422	14th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3244	16TH DIAG POA CODE IS MIS/INVALID	3423	15th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3245	17TH DIAG POA CODE IS MIS/INVALID	3424	16th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3246	18TH DIAG POA CODE IS MIS/INVALID	3425	17th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/invalid Present on Admission indicator.
3247	19TH DIAG POA CODE IS MIS/INVALID	3426	18th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/incomplete/Invalid Present on Admission indicator.
3248	20TH DIAG POA CODE IS MIS/INVALID	3427	19th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/incomplete/Invalid Present on Admission indicator.
3249	21ST DIAG POA CODE IS MIS/INVALID	3428	20th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3250	22ND DIAG POA CODE IS MIS/INVALID	3429	21st Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.
3251	23RD DIAG POA CODE IS MIS/INVALID	3430	22nd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.
3252	24TH DIAG POA CODE IS MIS/INVALID	3431	23rd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.
3253	25TH DIAG POA CODE IS MIS/INVALID	3432	24th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3299	HOLIDAY PAY TV MOD BILLED - NOT A HOLIDAY - DENY	2001	Deny Holiday Pay TV Modifier when not a holiday.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3300	PRICING: CALCULATE STATE SHARE AMOUNT	2002	Percentage needed to calculate State Share amount is not found.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3324	NON-COVERED MODIFIER DUE TO CMS TERMINATION	1142	This Modifier has been discontinued by CMS or AMA for the Date of Service(s).	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.
3335	ADMITTING DIAGNOSIS NOT COVERED	410	Admitting Diagnosis code is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
3336	ANESTHESIA BILLED QUANTITY RESTRICTION	513	Please Indicate Anesthesia Time For Services Rendered.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N203	Missing/incomplete/invalid anesthesia time/units.
3337	NON-COVERED PROC DUE TO CMS TERMINATION	247	Procedure code has been terminated by CMS, AMA or ADA for the Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3338	ANESTHESIA RELATED PROCEDURE CODE NOT ON FILE	820	Anesthesia related procedure code billed is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
3340	SERVICE NOT COVERED BY NV MEDICAID	3340	Service not covered by NV Medicaid.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
3344	PERCENT OF BILL RATE NOT FOUND	132	Percentage of Bill rate not found. Claim could not be processed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
3347	NO PAYABLE ACCOMMODATION CODE	609	No payable accommodation code on claim.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.
3349	ANCILLARY NOT PAYABLE FOR DENIED OBSERVATION CODE	3349	Ancillary Not Payable for Denied Observation Code.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N161	This drug/service/supply is covered only when the associated service is covered.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3351	BILL NURSING HOME FOR THIS SERVICE	1296	Bill Nursing Home for this service.	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
3352	SPC FOSTER CARE - ELIGIBILITY FORM 365 DAYS	3352	ELIGIBILITY CHECKLIST NOT COMPLETE OR MISSING, PLEASE CONTACT THE CARE COORDINATOR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
3353	SPECIALIZED FOSTER CARE CHECKLIST PT86	3352	ELIGIBILITY CHECKLIST NOT COMPLETE OR MISSING, PLEASE CONTACT THE CARE COORDINATOR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
3358	ALLOWED AMOUNT EXCEEDS THRESHOLD	509	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.	273	Coverage/program guidelines were exceeded.		
3363	NO PROCEDURE REIMBURSEMENT RULE FOR CLAIM REGION	1001	Procedure is not payable for this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3364	NO REVENUE REIMBURSEMENT RULE FOR CLAIM REGION	1005	Revenue code is not payable for this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3381	ABORTION CERTIFICATE REQUIRED - HDR	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3381	ABORTION CERTIFICATE REQUIRED - HDR	340	Consent Form must be signed and dated by recipient	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3381	ABORTION CERTIFICATE REQUIRED - HDR	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3381	ABORTION CERTIFICATE REQUIRED - HDR	346	Life of the mother is not indicated as being endangered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3381	ABORTION CERTIFICATE REQUIRED - HDR	347	Date of the recipient signature and the date of the person obtaining consent must be the same.	198	Precertification/notification/authorization /pre-treatment exceeded.	N351	Service date outside of the approved treatment plan service dates.
3381	ABORTION CERTIFICATE REQUIRED - HDR	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3381	ABORTION CERTIFICATE REQUIRED - HDR	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3381	ABORTION CERTIFICATE REQUIRED - HDR	351	Witness Section of Declaration is incomplete.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3381	ABORTION CERTIFICATE REQUIRED - HDR	3381	Abortion Certificate Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3382	ABORTION CERTIFICATE REQUIRED - DTL	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3382	ABORTION CERTIFICATE REQUIRED - DTL	340	Consent Form must be signed and dated by recipient	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3382	ABORTION CERTIFICATE REQUIRED - DTL	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3382	ABORTION CERTIFICATE REQUIRED - DTL	346	Life of the mother is not indicated as being endangered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT, Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3382	ABORTION CERTIFICATE REQUIRED - DTL	347	Date of the recipient signature and the date of the person obtaining consent must be the same.	198	Precertification/notification/authorization/pre-treatment exceeded.	N351	Service date outside of the approved treatment plan service dates.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3382	ABORTION CERTIFICATE REQUIRED - DTL	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3382	ABORTION CERTIFICATE REQUIRED - DTL	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3382	ABORTION CERTIFICATE REQUIRED - DTL	351	Witness Section of Declaration is incomplete.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3382	ABORTION CERTIFICATE REQUIRED - DTL	3381	Abortion Certificate Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3383	STERILIZATION FORM REQUIRED - HDR	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3383	STERILIZATION FORM REQUIRED - HDR	329	Physician on Recipient Statement does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3383	STERILIZATION FORM REQUIRED - HDR	334	RECIPIENT BELOW MIN AGE FOR CONSENT SIGNATURE	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3383	STERILIZATION FORM REQUIRED - HDR	335	Sterilization Done Outside Consent Time Limits	198	Precertification/notification/authorization /pre-treatment exceeded.	N351	Service date outside of the approved treatment plan service dates.
3383	STERILIZATION FORM REQUIRED - HDR	336	Statement of Person Obtaining Consent Not Completed	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3383	STERILIZATION FORM REQUIRED - HDR	338	Please Complete All Portions of the Federal Consent Form and Resubmit	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3383	STERILIZATION FORM REQUIRED - HDR	339	Interpreter's Statement Not Filled in Completely	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3383	STERILIZATION FORM REQUIRED - HDR	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3383	STERILIZATION FORM REQUIRED - HDR	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3383	STERILIZATION FORM REQUIRED - HDR	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3383	STERILIZATION FORM REQUIRED - HDR	350	The date of the interpreter's signature does not correspond to the date the recipient signed the form.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3383	STERILIZATION FORM REQUIRED - HDR	383	Length of Stay Cut Back by Date of Sterilization; No Consent Form on File	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N3	Missing consent form.
3383	STERILIZATION FORM REQUIRED - HDR	3383	Sterilization Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3384	STERILIZATION FORM REQUIRED - DTL	37	Claim Denied. Acknowledgement	251	The attachment/other documentation	N705	Incomplete/invalid documentation.
			/Consent Form Is Missing, Incomplete, or		that was received was incomplete or		
			Contains Invalid Information		deficient. The necessary information is		
					still needed to process the claim. At least		
					one Remark Code must be provided (may		
					be comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT).		
2224		222		250			
3384	STERILIZATION FORM REQUIRED - DTL	329	Physician on Recipient Statement does	250	The attachment/other documentation	N206	The supporting documentation does not
			not correspond to Physician on Claim		that was received was the incorrect		match the information sent on the claim.
					attachment/document. The expected		
					attachment/document is still missing. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT).		
3384	STERILIZATION FORM REQUIRED - DTL	334	RECIPIENT BELOW MIN AGE FOR	251	The attachment/other documentation	MA75	Missing/incomplete/invalid patient or
			CONSENT SIGNATURE		that was received was incomplete or		authorized representative signature.
					deficient. The necessary information is		
					still needed to process the claim. At least		
					one Remark Code must be provided (may		
					be comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT).		
3384	STERILIZATION FORM REQUIRED - DTL	335	Sterilization Done Outside Consent Time	198	Precertification/notification/authorization	N2F1	Service date outside of the approved
3364	STERILIZATION FORM REQUIRED - DTL	333	Limits	198	/pre-treatment exceeded.	N331	treatment plan service dates.
3384	STERILIZATION FORM REQUIRED - DTL	336	Statement of Person Obtaining Consent	251	The attachment/other documentation	N228	Incomplete/invalid consent form.
3304	STERILIZATION FORM REQUIRED - DTE	330	Not Completed	231	that was received was incomplete or	14220	incomplete/invalid consent form.
			Not completed		deficient. The necessary information is		
					still needed to process the claim. At least		
					one Remark Code must be provided (may		
					be comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT).		
					nemark code that is not an ALERTY.		
3384	STERILIZATION FORM REQUIRED - DTL	338	Please Complete All Portions of the	251	The attachment/other documentation	N228	Incomplete/invalid consent form.
			Federal Consent Form and Resubmit		that was received was incomplete or		
					deficient. The necessary information is		
					still needed to process the claim. At least		
					one Remark Code must be provided (may		
					be comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT).		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3384	STERILIZATION FORM REQUIRED - DTL	339	Interpreter's Statement Not Filled in Completely	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice	N228	Incomplete/invalid consent form.
3384	STERILIZATION FORM REQUIRED - DTL	343	Surgery Date on Payment Request Not Same as Consent Form	251	Remark Code that is not an ALERT). The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	N228	Incomplete/invalid consent form.
3384	STERILIZATION FORM REQUIRED - DTL	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	that was received was the incorrect attachment/document. The expected attachment/document is still missing. At	N206	The supporting documentation does not match the information sent on the claim.
3384	STERILIZATION FORM REQUIRED - DTL	349	Physician on Consent Form does not correspond to Physician on Claim	250	that was received was the incorrect	N206	The supporting documentation does not match the information sent on the claim.
					attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).		
3384	STERILIZATION FORM REQUIRED - DTL	350	The date of the interpreter's signature does not correspond to the date the recipient signed the form.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3384	STERILIZATION FORM REQUIRED - DTL	383	Length of Stay Cut Back by Date of Sterilization; No Consent Form on File	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N3	Missing consent form.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3384	STERILIZATION FORM REQUIRED - DTL	3383	Sterilization Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3385	HYSTERECTOMY FORM REQUIRED - HDR	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3385	HYSTERECTOMY FORM REQUIRED - HDR	334	RECIPIENT BELOW MIN AGE FOR CONSENT SIGNATURE	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3385	HYSTERECTOMY FORM REQUIRED - HDR	338	Please Complete All Portions of the Federal Consent Form and Resubmit	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3385	HYSTERECTOMY FORM REQUIRED - HDR	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3385	HYSTERECTOMY FORM REQUIRED - HDR	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3385	HYSTERECTOMY FORM REQUIRED - HDR	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3385	HYSTERECTOMY FORM REQUIRED - HDR	3385	Hysterectomy Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3386	HYSTERECTOMY FORM REQUIRED - DTL	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3386	HYSTERECTOMY FORM REQUIRED - DTL	334	RECIPIENT BELOW MIN AGE FOR CONSENT SIGNATURE	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3386	HYSTERECTOMY FORM REQUIRED - DTL	338	Please Complete All Portions of the Federal Consent Form and Resubmit	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3386	HYSTERECTOMY FORM REQUIRED - DTL	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3386	HYSTERECTOMY FORM REQUIRED - DTL	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3386	HYSTERECTOMY FORM REQUIRED - DTL	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3386	HYSTERECTOMY FORM REQUIRED - DTL	3385	Hysterectomy Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3400	MEDICAID CANNOT PAY FOR VACCINES	3400		96 -	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M41	We do not pay for this as the patient has no legal obligation to pay for this.
3415	NET TIME REQUIRED - SCHEDULED APPOINTMENT TIME	2402	NET Time Required - Scheduled Appointment Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
3416	NET TIME REQUIRED - ACTUAL DROP-OFF	2403	NET Time Required - Actual Drop-off Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
3417	NET TIME REQUIRED - SCHEDULED PICK- UP TIME	2404	NET Time Required - Scheduled Pick-up Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3418	NET TIME REQUIRED - ACTUAL PICK-UP TIME	2405	NET Time Required - Actual Pick-up Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
3709	ENCOUNTER TCN IS MISSING OR INVALID	2406	Encounter TCN is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
3710	DUPLICATE ENCOUNTER TCN SUBMITTED	2407	Duplicate Encounter TCN submitted.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
3711	ENCOUNTER CLAIM STATUS NOT PRESENT	2408	Encounter Claim Status is not Present.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
3712	ENCOUNTER PAID AMOUNT < 0	2409	Duplicate Encounter TCN submitted.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
3714	ENCOUNTER LINE PAID AMOUNT = 0	2410	Encounter Line Paid Amount is zero.	23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3715	ENCOUNTER LINE QUANTITY = 0 AND PAID AMOUNT > 0	2411	Encounter Line Quantity is zero and the Paid Amount is greater than zero.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
3718	CMO RECEIPT DATE NOT VALID	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3719	MEDICARE CROSSOVER IDENTIFIED CLAIM	2413	Medicare Crossover Identified Claim	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3723	ENCOUNTER TRIP NUMBER IS MISSING	2413	Medicare Crossover Identified Claim	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3724	ENCOUNTER INVALID NET PROCEDURE CODE	2416	Encounter Invalid NET Procedure Code.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3728	NO PROC REIMB RULE FOR RECIP AGE	1552	This procedure is age restricted. Member's age does not fall within the approved age range.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
3733	PROCEDURE RSTCN FOR REV CVG RULE	393	The revenue code and procedure code are in conflict. Please verify whether a HCPC can be used with this revenue code and ensure the procedure code is appropriate for the revenue code used.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
3738	NO PROC REIMB RULE FOR BENEFIT PLAN	1544	The service is not reimbursable for the member's benefit plan.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3739	NO REV REIMB RULE FOR BENEFIT PLAN	1544	The service is not reimbursable for the member's benefit plan.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3740	PRIMARY HDR DIAG RSTCN FOR REV COVERAGE RULE	1568	Revenue code is not covered with this principal header diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
3741	FAMILY PLANNING RSTCN FOR REV CVG RULE	1542	The revenue code has Family Planning restrictions.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3742	FAMILY PLANNING RSTCN FOR PROC CVG RULE	1541	The procedure code has Family Planning restrictions.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
3744	NO BENEFIT COVERAGE RULE FOR CLAIM REGION	1006	Service is not covered for claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3748	NO PROC REIMB RULE FOR CLAIM TYPE	1023	Procedure is not payable for this claim type.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3749	NO REV CODE REIMB RULE FOR CLAIM TYPE	1010	Revenue code is not payable for this claim type.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3768	NO PROC REIMB RULE FOR PROVIDER CONTRACT	1013	Claim is not payable for the billed procedure.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3803	GEO PROV RENDERING PROC REIMB RULE	1104	Service is not payable to rendering provider in this location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
3848	NO PROC REIMB RULE FOR GEO PROVBILL	1114	Service is not payable to billing provider in this location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
3853	BILLING PRO LOCATION STATUS - PROC CVG RULE	1560	Procedure is not covered with this billing provider location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

2055	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3855	BILLING PROV LOCATION STATUS - REV	1561	Revenue code is not covered with this	16	Claim/service lacks information or has	N258	Missing/incomplete/invalid billing
1	CVG RULE		billing provider location.		submission/billing error(s). Usage: Do not		provider/supplier address.
İ					use this code for claims		
İ					attachment(s)/other documentation. At		
İ					least one Remark Code must be provided		
İ					(may be comprised of either the NCPDP		
İ					Reject Reason Code, or Remittance Advice		
İ					Remark Code that is not an ALERT.) Refer		
İ					to the 835 Healthcare Policy Identification		
İ					Segment (loop 2110 Service Payment		
1					Information REF), if present.		
İ							
3858	NO PROC REIMB RULE FOR GEO LOC	1115	Service is not payable to recipient in this	96	Non-covered charge(s). At least one	M97	Not paid to practitioner when provided to
1	RECIP	1113	location.	30	Remark Code must be provided (may be	IVIST	patient in this place of service. Payment
İ	NEC:1		location.		comprised of either the NCPDP Reject		included in the reimbursement issued the
İ					Reason Code, or Remittance Advice		facility.
İ					Remark Code that is not an ALERT.) Usage:		racincy.
İ					Refer to the 835 Healthcare Policy		
İ					Identification Segment (loop 2110 Service		
İ					Payment Information REF), if present.		
İ							
3861	BILLING PROV LOCATION STATUS - PROC	1559	Billing Provider is not authorized to	96	Non-covered charge(s). At least one	N431	Not covered with this procedure.
ĺ	BILL RULE		provide service from billing location.		Remark Code must be provided (may be		
İ					comprised of either the NCPDP Reject		
İ					Reason Code, or Remittance Advice		
İ					Remark Code that is not an ALERT.) Usage:		
İ					Refer to the 835 Healthcare Policy		
İ					Identification Segment (loop 2110 Service		
1					Payment Information REF), if present.		
3863	BILLING PROV LOCATION STATUS - REV	1559	Billing Provider is not authorized to	96	Non-covered charge(s). At least one	N431	Not covered with this procedure.
1	BILL RULE		provide service from billing location.		Remark Code must be provided (may be		·
İ			·		comprised of either the NCPDP Reject		
1					Reason Code, or Remittance Advice		
İ					Remark Code that is not an ALERT.) Usage:		
İ					Refer to the 835 Healthcare Policy		
İ					Identification Segment (loop 2110 Service		
1					Payment Information REF), if present.		
3867	BILLING PROV LOCATION STATUS - REIMB	4550	Dilling Describes in set and set and	96	Non-consideration (a) Addition	N431	Not as and with this area of a
300/	REV RULE	1222	Billing Provider is not authorized to	ספ	Non-covered charge(s). At least one	11431	Not covered with this procedure.
	KEV KULE		provide service from billing location.		Remark Code must be provided (may be		
1		1	1		comprised of either the NCPDP Reject	I	
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy		
					Remark Code that is not an ALERT.) Usage:		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3869	PERFORMING PROV LOCATION STATUS - PROC CVG RULE	1562	Revenue code is not covered with this rendering provider location.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer	N258	Missing/incomplete/invalid billing provider/supplier address.
3871	PERFORMING PROV LOCATION STATUS - PROC BILL RULE	1558	Servicing Provider is not authorized to provide service from service location.	96	to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Non-covered charge(s). At least one Remark Code must be provided (may be	N431	Not covered with this procedure.
					comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.] Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
3872	PERFORMING PROV LOCATION STATUS REV BILL RULE	1558	Servicing Provider is not authorized to provide service from service location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3877	NO REV CODE REIMB RULE FOR LOCKIN PLAN	1563	The service is not payable under the client's lock-in plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT, Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3878	NO PROC BILLING RULE FOR LOCKIN PLAN	1563	The service is not payable under the client's lock-in plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT, Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3888	NO REIMBURSEMENT RULE FOR PLACE OF SERVICE	1557	Service is not payable for the billed place of service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N428	Not covered when performed in this place of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3896	PROCEDURE RSTCN FOR REV BILL RULE	1116	The Revenue Code requires an appropriate corresponding Procedure Code.	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.
3897	QUANTITY RESTRICTION ON REV BILLING RULE	1273	Quantity Billed is invalid for the Revenue Code.	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N587	Policy benefits have been exhausted.
3898	REVENUE CODE RESTRICTION ON ICD BILLING RULE	1550	ICD procedure was not billed with the appropriate revenue codes.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3904	BENEFIT PLAN GROUP RSTCN ON PROC BILLING RULE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
3905	BENEFIT PLAN GROUP RSTCN ON REV BILLING RULE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
3930	NO PROC REIMB RULE FOR BILLING PT/PS	182	Billing Provider is not certified to bill service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3932	NO PROC REIMB RULE FOR RENDERING PT/PS	1132	Rendering Provider Type and/or Specialty is not allowable for the service billed.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N198	Rendering provider must be affiliated with the pay-to provider.
3940	NO REV CODE REIMB RULE FOR BILLING PT/PS	182	Billing Provider is not certified to bill service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3958	NO REIMB RULE FOR PROC	1178	Service is not reimbursable for Date(s) of Service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N43	Bed hold or leave days exceeded.
3959	NO REIMB RULE FOR REV CODE	1178	Service is not reimbursable for Date(s) of Service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N43	Bed hold or leave days exceeded.
3960	MODIFIER RSTCN ON REIMB REV RULE	1579	Service is not payable for this modifier.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
3968	NO REV CODE REIMB RULE FOR TOB	229	The Type of Bill is not allowed for the service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
3969	NO REV CODE REIMB RULE FOR PROVIDER CONTRACT	1580	Revenue code not covered under provider?s contract.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4006	AMOUNT PAID HIGH VARIANCE	509	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.	273	Coverage/program guidelines were exceeded.		
4009	ALLOWED AMT MORE THAN BILLED AMOUNT VARIANCE	509	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.	273	Coverage/program guidelines were exceeded.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4013	PROCEDURE CODE IS NOT COVERED FOR DATE OF SERV	3261	The procedure code currently is not a benefit for date of service billed. Refer to the CPT or the HCPCS listing for valid procedure codes.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
4014	NO PRICING SEGMENT ON FILE	3893	No Pricing Segment on File	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4021	NO CVG RULE FOR PROCEDURE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
4027	PRINCIPAL DIAGNOSIS NOT COVERED	411	Principal Diagnosis code is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4028	GENDER RESTRICTION FOR DIAG CVG RULE	1120	One or more Diagnosis Codes has a gender restriction.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4029	2ND DIAGNOSIS NOT COVERED	412	1st Other Diagnosis (Institutional), 2nd Diagnosis Code (Professional/Dental) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4030	AGE RESTRICTION ON DIAG CVG RULE	1119	One or more Diagnosis Codes has an age restriction.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4031	GENDER RESTRICTION FOR DIAG BILLING RULE	801	One or more diagnosis codes are not applicable to the client's gender.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_COD	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4032	PROCEDURE CODE NOT ON FILE	3180	The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
4033	3RD DIAGNOSIS NOT COVERED	413	2nd Other Diagnosis (Institutional), 3rd Diagnosis Code (Professional/Dental) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4034	AGE RESTRICTION ON PROC CVG RULE	1121	Member does not meet the age restriction for this Procedure Code.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4036	PLACE OF SERVICE RESTRICTION ON PROC CVG RULE	1197	The Procedure Code has Place of Service restrictions.	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
4038	4TH DIAGNOSIS NOT COVERED	414	3rd Other Diagnosis (Institutional), 4th Diagnosis Code (Professional/Dental) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4039	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS	61	Diagnosis cannot be used as a principal diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.
4040	2ND DIAGNOSIS CODE NOT ON FILE	3720	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4041	3RD DIAGNOSIS CODE NOT ON FILE	3730	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4042	4TH DIAGNOSIS CODE NOT ON FILE	3740	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis Code (Professional/Dental) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4043	5TH DIAGNOSIS CODE NOT ON FILE	3930	The 4th Other Diagnosis code (Institutional), 5th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4044	12TH DIAGNOSIS CODE NOT ON FILE	7319	The 11th Other Diagnosis Code (Institutional), 12th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4045	11TH DIAGNOSIS CODE NOT ON FILE	7313	The 10th Other Diagnosis Code (Institutional), 11th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4046	PROCEDURE CODE NOT EFFECTIVE FOR DOS	3181	The procedure code is invalid for date of service. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
4047	6TH DIAGNOSIS CODE NOT ON FILE	5260	The 5th Other Diagnosis code (Institutional), 6th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4048	7TH DIAGNOSIS CODE NOT ON FILE	5270	The 6th Other Diagnosis code (Institutional), 7th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4049	8TH DIAGNOSIS CODE NOT ON FILE	5280	The 7th Other Diagnosis code (Institutional), 8th Diagnosis Code (Professional) is invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4050	9TH DIAGNOSIS CODE NOT ON FILE	5290	The 8th Other Diagnosis code (Institutional), 9th Diagnosis Code (Professional) is invalid. Correct the diagnosis.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4051	10TH DIAGNOSIS CODE NOT ON FILE	7307	The 9th Other Diagnosis Code (Institutional), 10th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4052	ADMITTING DIAGNOSIS CODE NOT ON FILE	1264	Admit Diagnosis is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.
4053	PRINCIPAL ICD PROCEDURE CODE NOT ON FILE	870	The Principal ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4054	1ST OTHER ICD PROCEDURE CODE NOT ON FILE	871	The 1st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4055	2ND OTHER ICD PROCEDURE CODE NOT ON FILE	872	The 2nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4056	3RD OTHER ICD PROCEDURE CODE NOT ON FILE	873	The 3rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims	M67	Missing/incomplete/invalid other procedure code(s).
			code.	attachment(s)/other documentation. At least one Remark Code must be provided			
					(may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4057	4TH OTHER ICD PROCEDURE CODE NOT	874	The 4th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure code.		submission/billing error(s). Usage: Do not use this code for claims		procedure code(s).
					attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
					inormation tery, it present.		
4058	5TH OTHER ICD PROCEDURE CODE NOT ON FILE	875	The 5th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims	M67	Missing/incomplete/invalid other procedure code(s).
					attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment Information REF), if present.		
4059	REVENUE CODE NOT ON FILE	3752	The revenue code is not on file. Refer to	16	Claim/service lacks information or has	M50	Missing/incomplete/invalid revenue
			the current revenue code table for valid codes.		submission/billing error(s). Usage: Do not use this code for claims		code(s).
					attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4061	13TH DIAGNOSIS CODE NOT ON FILE	7325	The 12th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
			(Institutional) is invalid. Correct the diagnosis code.		service reported.		condition.
4063	5TH DIAGNOSIS NOT COVERED	415	4th Other Diagnosis (Institutional), 5th Diagnosis Code (Professional) is not	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
			covered.		· ·		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4064	6TH DIAGNOSIS NOT COVERED	416	5th Other Diagnosis (Institutional), 6th	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
			Diagnosis Code (Professional) is not		service reported.		condition.
			covered.				
4065	7TH DIAGNOSIS NOT COVERED	417	6th Other Diagnosis (Institutional), 7th	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
			Diagnosis Code (Professional) is not		service reported.		condition.
			covered.				
4067	1ST OTHER ICD PROCEDURE NOT	561	The 1st Other ICD Procedure is not a	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	COVERED		Covered Benefit.		submission/billing error(s). Usage: Do not		procedure code(s).
					use this code for claims		, , ,
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information KEF), if present.		
4068	8TH DIAGNOSIS NOT COVERED	418	7th Other Diagnosis (Institutional), 8th	96	Non-covered charge(s). At least one	N569	Not covered when performed for the
4008	8 TH DIAGNOSIS NOT COVERED	416		96	- · · ·	10009	·
			Diagnosis Code (Professional) is not		Remark Code must be provided (may be		reported diagnosis.
			covered.		comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4069	9TH DIAGNOSIS NOT COVERED	477	Services with the 8th Other Diagnosis	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
			code are not a benefit.		service reported.		condition.
4070	MODIFIER RESTRICTION FOR PROC	1512	The Procedure Code/Modifier	4	The procedure code is inconsistent with		
	REIMBURSEMENT RULE		combination is not payable for the Date of		the modifier used. Usage: Refer to the 835		
			Service.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4071	10TH DIAGNOSIS NOT COVERED	420	9th Other Diagnosis code (Institutional),	96	Non-covered charge(s). At least one	N569	Not covered when performed for the
			10th Diagnosis Code (Professional) is not		Remark Code must be provided (may be		reported diagnosis.
			covered.		comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4072	11TH DIAGNOSIS NOT COVERED	421	10th Other Diagnosis code (Institutional),	96	Non-covered charge(s). At least one	N569	Not covered when performed for the
			11th Diagnosis Code (Professional) is not		Remark Code must be provided (may be		reported diagnosis.
			covered.		comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
1					Refer to the 835 Healthcare Policy		
					1		
					Identification Segment (loop 2110 Service		
					Identification Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4073	12TH DIAGNOSIS NOT COVERED	422	11th Other Diagnosis code (Institutional), 12th Diagnosis Code (Professional) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4074	13TH DIAGNOSIS NOT COVERED	423	12th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4075	14TH DIAGNOSIS NOT COVERED	424	13th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4076	15TH DIAGNOSIS NOT COVERED	425	14th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4077	REVENUE CODE NOT EFFECTIVE FOR DOS	1187	The Revenue Code is not payable for the Date(s) of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
4078	16TH DIAGNOSIS NOT COVERED	426	15th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4079	17TH DIAGNOSIS NOT COVERED	427	16th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4080	18TH DIAGNOSIS NOT COVERED	428	17th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4082	19TH DIAGNOSIS NOT COVERED	429	18th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4083	20TH DIAGNOSIS NOT COVERED	430	19th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4084	ALLOWED AMT LESS THAN BILLED AMOUNT VARIANCE	507	ALLOWED AMOUNT LESS THAN BILLED AMOUNT VARIANCE.	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.		
4086	21ST DIAGNOSIS NOT COVERED	431	20th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODI	E ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4087	22ND DIAGNOSIS NOT COVERED	432	21st Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4089	MISSING/INVALID HCPCS SURGICAL CDE/SURGERY REV	2860	ASC Rate cannot be determined - Missing or Invalid HCPCS Surgical Code/Revenue Code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4090	23RD DIAGNOSIS NOT COVERED	433	22nd Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4091	24TH DIAGNOSIS NOT COVERED	434	23rd Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4092	25TH DIAGNOSIS NOT COVERED	435	24th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4093	2ND DIAG GENDER CONFLICT	3242	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis Code (Professional/Dental) is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1094	3RD DIAG GENDER CONFLICT	3243	The 2nd Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 3rd Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			sex. Correct the diagnosis code/sex		(loop 2110 Service Payment Information		
			indicator.		REF), if present.		
4096	4TH DIAG GENDER CONFLICT	3244	The 3rd Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 4th Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			sex. Correct the diagnosis code/sex		(loop 2110 Service Payment Information		
			indicator.		REF), if present.		
4101	5TH DIAG GENDER CONFLICT	1105	The 4th Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 5th Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional) is invalid for client's sex.		Healthcare Policy Identification Segment		
			Correct the diagnosis code/sex indicator.		(loop 2110 Service Payment Information		
					REF), if present.		
4102	6TH DIAG GENDER CONFLICT	1106	The 5th Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 6th Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional) is invalid for client's sex.		Healthcare Policy Identification Segment		
			Correct the diagnosis code/sex indicator.		(loop 2110 Service Payment Information		
					REF), if present.		
4103	7TH DIAG GENDER CONFLICT	1107	The 6th Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 7th Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional) is invalid for client's sex.		Healthcare Policy Identification Segment		
			Correct the diagnosis code/sex indicator.		(loop 2110 Service Payment Information		
					REF), if present.		
4104	8TH DIAG GENDER CONFLICT	1108	The 7th Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 8th Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional) is invalid for client's sex		Healthcare Policy Identification Segment		
			Correct the diagnosis code/sex indicator.		(loop 2110 Service Payment Information		
					REF), if present.		
4105	NO FLAT FEE ON FILE	139	No Flat Fee on File.	16	Claim/service lacks information or has	N65	Procedure code or procedure rate count
					submission/billing error(s). Usage: Do not		cannot be determined, or was not on file,
					use this code for claims		for the date of service/provider.
					attachment(s)/other documentation. At		, , , ,
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KET J, ii present.		
4106	9TH DIAG GENDER CONFLICT	1109	The 8th Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
4100	JIII DIAG GENDER CONFLICT	1103	(Institutional), 9th Diagnosis Code	10	patients gender. Usage: Refer to the 835	INJ1/	information.
			(Professional) is invalid for client's sex		Healthcare Policy Identification Segment		mormation.
			Correct the diagnosis code/sex indicator.		(loop 2110 Service Payment Information		
			correct the diagnosis code/sex mulcator.		REF), if present.		
4107	10TH DIAG GENDER CONFLICT	7310	The 9th Other Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
4107	TOTH DIAG GENDER CONFLICT	1310	(Institutional), 10th Diagnosis Code	10	patients gender. Usage: Refer to the 835	INDII	information.
							ino mation.
			(Professional) is invalid for client's sex.		Healthcare Policy Identification Segment		
			Correct the diagnosis code/sex indicator.		(loop 2110 Service Payment Information		
		1		1	REF), if present.	1	

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4108	NO ASC ON FILE	140	Surgery Code does not have ASC level.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4109	11TH DIAG GENDER CONFLICT	7316	The 10th Other Diagnosis code (Institutional), 11th Diagnosis Code (Professional) is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4110	12TH DIAG GENDER CONFLICT	7322	The 11th Other Diagnosis code (Institutional), 12th Diagnosis Code (Professional) is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4111	13TH DIAG GENDER CONFLICT	7328	The 12th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4116	14TH DIAG GENDER CONFLICT	7334	The 13th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4117	15TH DIAG GENDER CONFLICT	7340	The 14th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4118	16TH DIAG GENDER CONFLICT	7346	The 15th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4119	17TH DIAG GENDER CONFLICT	7352	The 16th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4120	PROCEDURE CODE REQUIRES AREA OF	1145	Area of the Oral Cavity is required for	16	Claim/service lacks information or has	N346	Missing/incomplete/invalid oral cavity
	ORAL CAVITY		Procedure Code.		submission/billing error(s). Usage: Do not		designation code.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4121	18TH DIAG GENDER CONFLICT	7358	The 17th Other Diagnosis code is invalid	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			for client's sex. Correct the diagnosis		patients gender. Usage: Refer to the 835		information.
			code/sex indicator.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4122	19TH DIAG GENDER CONFLICT	7364	The 18th Other Diagnosis code is invalid	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			for client's sex. Correct the diagnosis		patients gender. Usage: Refer to the 835		information.
			code/sex indicator.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4125	20TH DIAG GENDER CONFLICT	7370	The 19th Other Diagnosis code is invalid	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			for client's sex. Correct the diagnosis		patients gender. Usage: Refer to the 835		information.
			code/sex indicator.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4127	CANNOT PRIORITIZE CLIENTS BENEFIT	0	This claim/service is pending for program	133	The disposition of this service line is	N10	Adjustment based on the findings of a
	PLANS		review.		pending further review. (Use only with		review organization/professional
					Group Code OA). Usage: Use of this code		consult/manual adjudication/medical
					requires a reversal and correction when		advisor/dental advisor/peer review.
					the service line is finalized (use only in		
					Loop 2110 CAS segment of the 835 or		
					Loop 2430 of the 837).		
4128	6TH OTHER ICD PROCEDURE CODE NOT	876	The 6th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4129	21ST DIAG GENDER CONFLICT	7376	The 20th Other Diagnosis code is invalid	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			for client's sex. Correct the diagnosis		patients gender. Usage: Refer to the 835		information.
			code/sex indicator.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
		<u> </u>			REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4130	PAYER HIERARCHY NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4131	NO BENEFIT PLANS ASSOCIATED TO PAYE	R O	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4136	22ND DIAG GENDER CONFLICT	7382	The 21st Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4137	23RD DIAG GENDER CONFLICT	7388	The 22nd Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4139	24TH DIAG GENDER CONFLICT	7394	The 23rd Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4140	25TH DIAG GENDER CONFLICT	7400	The 24th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4141	PERF/FACILITY PT/PS RESTRICTION ON PROC CVG RULE	1388	The Procedure Code is not reimbursable for the Rendering Provider Type and/or Specialty.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N808	Not covered for this provider type / provider specialty.
4142	ADMITTING DIAG GENDER CONFLICT	1100	The admitting diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4143	BILLING PT/PS RESTRICTION ON REV CODE	182	Billing Provider is not certified to bill	96	Non-covered charge(s). At least one	N130	Consult plan benefit
	CVG RULE		service.		Remark Code must be provided (may be		documents/guidelines for information
					comprised of either the NCPDP Reject		about restrictions for this service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment information KEr), it present.		
4144	PERF/FACILITY PT/PS RESTRICTION ON	558	The service requested is not allowable for	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	DIAG BILL RULE		the Diagnosis indicated.		procedure. Usage: Refer to the 835		diagnosis.
			_		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4145	2ND DIAG AGE CONFLICT	3232	The 1st Other Diagnosis code	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 2nd Diagnosis code		patients age. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			age. Correct the diagnosis code/client's		(loop 2110 Service Payment Information		
			birth		REF), if present.		
4146	3RD DIAG AGE CONFLICT	3233	The 2nd Other Diagnosis code	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 3rd Diagnosis code		patients age. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			age. Correct the diagnosis code/client's		(loop 2110 Service Payment Information		
			birth		REF), if present.		
4147	4TH DIAG AGE CONFLICT	3234	The 3rd Other Diagnosis code	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 4th Diagnosis code		patients age. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			age. Correct the diagnosis code/client's		(loop 2110 Service Payment Information		
			birth		REF), if present.		
4148	5TH DIAG AGE CONFLICT	3235	The 4th Other Diagnosis code	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 5th Diagnosis code		patients age. Usage: Refer to the 835		information.
			(Professional) is invalid for client's age.		Healthcare Policy Identification Segment		
			Correct the diagnosis code/client's birth		(loop 2110 Service Payment Information		
			date.		REF), if present.		
4149	BILLING PT/PS RESTRICTION ON PROC	182	Billing Provider is not certified to bill	96	Non-covered charge(s). At least one	N130	Consult plan benefit
	BILLING RULE		service.		Remark Code must be provided (may be		documents/guidelines for information
					comprised of either the NCPDP Reject		about restrictions for this service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment information KET J, ii present.		
4150	PERF/FACILITY PT/PS RESTRICTION PROC	1280	Rendering Provider is not certified to	96	Non-covered charge(s). At least one	N130	Consult plan benefit
	BILLING RULE		perform procedure billed.		Remark Code must be provided (may be		documents/guidelines for information
		1	F		comprised of either the NCPDP Reject		about restrictions for this service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment information ker), it present.		
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ERROR_COD	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4151	BILLING PT/PS RESTRICTION ON REV COD	E 3020	Billing Provider Type and/or Specialty is	96	Non-covered charge(s). At least one	N130	Consult plan benefit
	BILLING RULE		not allowable for the revenue code billed.		Remark Code must be provided (may be		documents/guidelines for information
					comprised of either the NCPDP Reject		about restrictions for this service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4152	6TH DIAG AGE CONFLICT	3236	The 5th Other Diagnosis (Institutional),	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			6th Diagnosis code (Professional) is invalid		patients age. Usage: Refer to the 835		information.
			for client's age. Correct the diagnosis		Healthcare Policy Identification Segment		
			code/client's birth date.		(loop 2110 Service Payment Information		
			, , , , , , , , , , , , , , , , , , , ,		REF), if present.		
4154	7TH DIAG AGE CONFLICT	3237	The 6th Other Diagnosis (Institutional) 7th	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			Diagnosis Code (Professional) is invalid for		patients age. Usage: Refer to the 835		information.
			client's age. Correct the diagnosis		Healthcare Policy Identification Segment		
			code/client's birth date.		(loop 2110 Service Payment Information		
					REF), if present.		
4155	8TH DIAG AGE CONFLICT	3238	The 7th Other Diagnosis (Institutional),	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			8th Diagnosis Code (Professional) is		patients age. Usage: Refer to the 835		information.
			invalid for client's age. Correct the		Healthcare Policy Identification Segment		
			diagnosis code/client's birth date.		(loop 2110 Service Payment Information		
			and ground to deep chemic of the first date.		REF), if present.		
4156	9TH DIAG AGE CONFLICT	3239	The 8th Other Diagnosis (Institutional),	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
1250	3111 5111 6 71 6 2 6 6 111 E1 6 1	5255	9th Diagnosis code (Professional) is invalid		patients age. Usage: Refer to the 835	11327	information.
			for client's age. Correct the diagnosis		Healthcare Policy Identification Segment		in or mation.
			code/client's birth date.		(loop 2110 Service Payment Information		
			code/cheric's birth date.		REF), if present.		
4157	10TH DIAG AGE CONFLICT	3268	The 9th Other Diagnosis (Institutional),	q	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
4157	10111 DIAG AGE CONTEICT	3200	10th Diagnosis code (Professional) is		patients age. Usage: Refer to the 835	14517	information.
			invalid for client's age. Correct the		Healthcare Policy Identification Segment		intermedian.
			diagnosis code/client's birth date.		(loop 2110 Service Payment Information		
			diagnosis code/client s birtir date.		REF), if present.		
4158	11TH DIAG AGE CONFLICT	7315	The 10th Other Diagnosis (Institutional),	0	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
4130	IIIII DIAG AGE CONFEICI	7313	11th Diagnosis Code (Professional) is	3	patients age. Usage: Refer to the 835	14317	information.
			invalid for client's age. Correct the		Healthcare Policy Identification Segment		information.
			diagnosis code/client's birth date.		(loop 2110 Service Payment Information		
			diagnosis code/client's bil til date.		REF), if present.		
4159	12TH DIAG AGE CONFLICT	7321	The 11th Other Diagnosis (Institututional),	0	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
4133	12 ITI DIAG AGE CONFLICT	7321	12th Diagnosis Code (Professional) is	3	patients age. Usage: Refer to the 835	INJ1/	information.
			- · · · · · · · · · · · · · · · · · · ·				illiorniacion.
			invalid for client's age. Correct the		Healthcare Policy Identification Segment		
			diagnosis code/client's birth date.		(loop 2110 Service Payment Information		
44.50	42TH BIAC ACE CONFILCT	7227	The 43th Other Diegonic is invested for		REF), if present.	NE47	Described to a secondarior with the secondarior
4160	13TH DIAG AGE CONFLICT	7327	The 12th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
1			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
44.54	AATH DIAC ACE CONFLICT	7222	The 42th Other Diseases is in 1915		REF), if present.	NE47	Described to a secondarion with the
4161	14TH DIAG AGE CONFLICT	7333	The 13th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis	Ì	patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
				Ì	(loop 2110 Service Payment Information		
1					REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1162	15TH DIAG AGE CONFLICT	7339	The 14th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4163	QUANTITY RESTRICTION ON PROC BILLING	1275	Quantity Billed is restricted for this	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	RULE		Procedure Code.		occurrence has been reached.		exceeds our acceptable maximum.
4165	16TH DIAG AGE CONFLICT	7345	The 15th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4166	17TH DIAG AGE CONFLICT	7351	The 16th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4167	18TH DIAG AGE CONFLICT	7357	The 17th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
			,		(loop 2110 Service Payment Information		
					REF), if present.		
4168	19TH DIAG AGE CONFLICT	7363	The 18th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
1200	15 TH BING NOL GOTH LICE	7505	client's age. Correct the diagnosis		patients age. Usage: Refer to the 835	1.527	information.
			code/client's birth date.		Healthcare Policy Identification Segment		
			dode, onene s on an date.		(loop 2110 Service Payment Information		
					REF), if present.		
4173	20TH DIAG AGE CONFLICT	7369	The 19th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
4175	ZOTT BIAG AGE CONTEICT	7303	client's age. Correct the diagnosis		patients age. Usage: Refer to the 835	14517	information.
			code/client's birth date.		Healthcare Policy Identification Segment		
			code, cheffe 3 bit it date.		(loop 2110 Service Payment Information		
					REF), if present.		
4177	21ST DIAG AGE CONFLICT	7375	The 20th Other Diagnosis is invalid for	0	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
41//	2131 DIAG AGE CONFEICT	/3/3	client's age. Correct the diagnosis	3	patients age. Usage: Refer to the 835	11317	information.
			code/client's birth date.		Healthcare Policy Identification Segment		inormation.
			code/client's birth date.		(loop 2110 Service Payment Information		
					REF), if present.		
4179	22ND DIAG AGE CONFLICT	7381	The 21st Other Diagnosis is invalid for	0	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
41/9	22ND DIAG AGE CONFLICT	/361	client's age. Correct the diagnosis	9	patients age. Usage: Refer to the 835	NS17	information.
			code/client's birth date.		Healthcare Policy Identification Segment		information.
			code/client's birth date.				
					(loop 2110 Service Payment Information		
4400	1 4 1 5 DD OFFSSSON 1 4 1	4500	0	440	REF), if present.	NO.CO	7
4180	MUE PROFESSIONAL	1690	Quantity indicated for this service exceeds	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
			the maximum quantity limit established		occurrence has been reached.		exceeds our acceptable maximum.
			by the National Correct Coding Initiative.				
4404		1500	0 11 15 15 15	440	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NO.CO	T
4181	MUE DME	1690	Quantity indicated for this service exceeds	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
			the maximum quantity limit established		occurrence has been reached.		exceeds our acceptable maximum.
			by the National Correct Coding Initiative.				
4182	MUE OUTPATIENT	1690	Quantity indicated for this service exceeds	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
		1	the maximum quantity limit established		occurrence has been reached.		exceeds our acceptable maximum.
			by the National Correct Coding Initiative.				
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4187	23RD DIAG AGE CONFLICT	7387	The 22nd Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4188	24TH DIAG AGE CONFLICT	7393	The 23rd Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4189	25TH DIAG AGE CONFLICT	7399	The 24th Other Diagnosis is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4190	ADMITTING DIAG AGE CONFLICT	3230	The admitting diagnosis code is invalid for	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			client's age. Correct the diagnosis		patients age. Usage: Refer to the 835		information.
			code/client's birth date.		Healthcare Policy Identification Segment		
			, , , , , , , , , , , , , , , , , , , ,		(loop 2110 Service Payment Information		
					REF), if present.		
4191	PRINCIPAL DIAG AGE CONFLICT	3231	The Principal Diagnosis code	9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 1st Diagnosis code		patients age. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			age. Correct the diagnosis code/client's		(loop 2110 Service Payment Information		
			birth		REF), if present.		
4192	PRINCIPAL DIAG GENDER CONFLICT	3241	The Principal Diagnosis code	10	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested
			(Institutional), 1st Diagnosis Code		patients gender. Usage: Refer to the 835		information.
			(Professional/Dental) is invalid for client's		Healthcare Policy Identification Segment		
			sex.Correct the diagnosis code/sex		(loop 2110 Service Payment Information		
			indicator.		REF), if present.		
4193	Diagnosis codes P00-P96 diag age conflict	4193	Diagnosis code age restriction does not	9	The diagnosis is inconsistent with the	N129	Not eligible due to the patients age.
			match recipient.		patients age. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4194	DIAGNOSIS CODES P00-P96 DIAG AGE	4193	Diagnosis code age restriction does not	9	The diagnosis is inconsistent with the	N129	Not eligible due to the patients age.
	CONFLICT - DENY		match recipient.		patients age. Usage: Refer to the 835		g p
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4200	CLAIM PRICED AT ZERO	42	Claim Priced at zero.	204	This service/equipment/drug is not		<u> </u>
		·-		[covered under the patients current		
					benefit plan		
4208	CLIA LICENSE NUMBER INVALID	793	PROVIDER NOT CLIA CERTIFIED TO	B7	This provider was not certified/eligible to	MA120	Missing/incomplete/invalid CLIA
	Table 1 and	[PERFORM LAB PROCEDURE.	Ī	be paid for this procedure/service on this		certification number.
					date of service. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
l	i e	I	1	i	nei j, ii present.	1	

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4209	NO PRICING SEGMENT FOR	3530	There is no rate on file for	16	Claim/service lacks information or has	N65	Procedure code or procedure rate count
	PROCEDURE/MODIFIER COMB		procedure/modifier combination for the		submission/billing error(s). Usage: Do not		cannot be determined, or was not on file,
			date of service. Charges cannot be		use this code for claims		for the date of service/provider.
			processed.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4211	TOOTH NUMBER/PROCEDURE CODE	364	-	96	Non-covered charge(s). At least one	N39	Procedure code is not compatible with
	COMBINATION INVALID		Tooth number on claim is not valid with		Remark Code must be provided (may be		tooth number/letter.
			the submitted procedure code. Please		comprised of either the NCPDP Reject		
			correct and resubmit your claim.		Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4219	MEDICAL REVIEW FOR REV CODE CVG	325	Non-Emergent Services not Authorized for	40	Charges do not meet qualifications for	N10	Adjustment based on the findings of a
	RULE - DENY		Non-Citizens		emergent/urgent care. Usage: Refer to		review organization/professional
					the 835 Healthcare Policy Identification		consult/manual adjudication/medical
					Segment (loop 2110 Service Payment		advisor/dental advisor/peer review.
					Information REF), if present.		
4220	REVIEW C-SECTION FOR MEDICAL	4222	REVIEW C-SECTION FOR MEDICAL	50	These are non-covered services because	N661	Documentation does not support that the
	NECESSITY - DENY		NECESSITY		this is not deemed a medical necessity by		services rendered were medically
					the payer. Usage: Refer to the 835		necessary.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4221	MEDICAL REVIEW FOR PROC CVG RULE -	325	Non-Emergent Services not Authorized for	40	Charges do not meet qualifications for	N10	Adjustment based on the findings of a
	DENY		Non-Citizens		emergent/urgent care. Usage: Refer to		review organization/professional
					the 835 Healthcare Policy Identification		consult/manual adjudication/medical
					Segment (loop 2110 Service Payment		advisor/dental advisor/peer review.
					Information REF), if present.		
4222	REVIEW C-SECTION FOR MEDICAL	4222		50		N661	Documentation does not support that the
	NECESSITY]	NECESSITY		this is not deemed a medical necessity by		services rendered were medically
					the payer. Usage: Refer to the 835		necessary.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4223	MEDICAL REVIEW FOR PROC CVG RULE	325	Non-Emergent Services not Authorized for	40	Charges do not meet qualifications for	N10	Adjustment based on the findings of a
			Non-Citizens		emergent/urgent care. Usage: Refer to		review organization/professional
					the 835 Healthcare Policy Identification		consult/manual adjudication/medical
					Segment (loop 2110 Service Payment		advisor/dental advisor/peer review.
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4224	NO INPATIENT PA FOR NON-EMERGENT NON-CITIZEN SVCS	325	Non-Emergent Services not Authorized for Non-Citizens	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4227	NO CVG RULE FOR REVENUE CODE	1378	The Revenue Code is not payable for the Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
4238	SERVICE NOT VALID FOR LAST 7 DAYS OF HOSPICE	600	SERVICE NOT VALID FOR LAST 7 DAYS OF HOSPICE	B9	Patient is enrolled in a Hospice.		
4239	RECIPIENT NOT ENROLLED WITH LOC/HOSPICE	4239	RECIPIENT NOT ENROLLED WITH LOC/HOSPICE.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4240	1ST DIAGNOSIS CODE NOT ON FILE	3130	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	м76	Missing/incomplete/invalid diagnosis or condition.
4241	UNABLE TO DETERMINE LEVEL OF CARE	404	The member has no Level of Care (LOC) authorization on file or the LOC on file does not match the LOC on the claim.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N188	The approved level of care does not match the procedure code submitted.
4244	NO CVG RULE FOR DIAGNOSIS	1190	One or more Diagnosis Code(s) is not payable for the Date of Service.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4245	FOURTH MODIFIER INVALID	1514	The fourth modifier code is invalid for date of service.	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4247	PRINCIPAL ICD PROCEDURE NOT COVERED	2300	The Principal ICD Procedure is not a Covered Benefit.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
4248	2ND OTHER ICD PROCEDURE NOT COVERED	571	The 2nd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid other procedure code(s).
4249	3RD OTHER ICD PROCEDURE NOT COVERED	522	The 3rd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid other procedure code(s).
4250	4TH OTHER ICD PROCEDURE NOT COVERED	527	The 4th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/Other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE	626	Decimal Units Not Billable for Service - Please bill with whole number quantity.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
4252	14TH DIAGNOSIS CODE NOT ON FILE	7331	The 13th Other Diagnosis Code (Institutional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4253	MEDICAL REVIEW FOR REV CODE CVG RULE	325	Non-Emergent Services not Authorized for Non-Citizens	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4254	AGE RESTRICTION ON REV CODE CVG RULE	45	The Service Requested Does Not Correspond With Age Criteria.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4255	MODIFIER RESTRICTION ON REV CODE BILLING RULE	1579	Service is not payable for this modifier.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
4256	MODIFIER RESTRICTION FOR PROC CVG RULE	1553	The procedure code and modifier combination is not covered for the client's benefit plan.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519	Invalid combination of HCPCS modifiers.
4257	MODIFIER RESTRICTION FOR PROC BILLING RULE	859	REQUIRED MODIFIER IS NOT PRESENT ON THE CLAIM. PLEASE RESUBMIT.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N822	Missing procedure modifier(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4258	STH OTHER ICD PROCEDURE NOT COVERED	562	The 5th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4259	6TH OTHER ICD PROCEDURE NOT COVERED	2306	The 6th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4260	7TH OTHER ICD PROCEDURE NOT COVERED	2307	The 7th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4261	8TH OTHER ICD PROCEDURE NOT COVERED	2308	The 8th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4262	9TH OTHER ICD PROCEDURE NOT COVERED	2309	The 9th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4263	10TH OTHER ICD PROCEDURE NOT COVERED	2310	The 10th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4264	11TH OTHER ICD PROCEDURE NOT COVERED	2311	The 11th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4265	12TH OTHER ICD PROCEDURE NOT COVERED	2312	The 12th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4266	14TH OTHER ICD PROCEDURE NOT COVERED	2314	The 14th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4267	15TH OTHER ICD PROCEDURE NOT COVERED	2315	The 15th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4268	16TH OTHER ICD PROCEDURE NOT COVERED	2316	The 16th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4269	17TH OTHER ICD PROCEDURE NOT COVERED	2317	The 17th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4270	18TH OTHER ICD PROCEDURE NOT COVERED	2318	The 18th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4271	19TH OTHER ICD PROCEDURE NOT COVERED	2319	The 19th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4272	20TH OTHER ICD PROCEDURE NOT COVERED	2320	The 20th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4273	21ST OTHER ICD PROCEDURE NOT COVERED	2321	The 21st Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4274	22ND OTHER ICD PROCEDURE NOT	2322	The 22nd Other ICD Procedure is not a	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	COVERED		Covered Benefit.		submission/billing error(s). Usage: Do not		procedure code(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4275	23RD OTHER ICD PROCEDURE NOT	2323	The 22ad Other ICD December is not a	16	Claim form in last information on her	M67	National description of the second se
42/5	COVERED	2323	The 23rd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not	IVI67	Missing/incomplete/invalid other
	COVERED		Covered Benefit.		use this code for claims		procedure code(s).
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4276	24TH OTHER ICD PROCEDURE NOT	2324	The 24th Other ICD Procedure is not a	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	COVERED		Covered Benefit.		submission/billing error(s). Usage: Do not		procedure code(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4277	THE OTHER ICE PROCESSION CORE	077	The 7th Other ICD D	46	Claim / anning lanks is 5	NAC7	Malacina di manusalata di Malacina di Mala
4277	7TH OTHER ICD PROCEDURE CODE NOT	877	The 7th Other ICD Procedure Code is not	10	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
		1		1			

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4278	8TH OTHER ICD PROCEDURE CODE NOT	878	The 8th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					presenti		
4279	9TH OTHER ICD PROCEDURE CODE NOT	879	The 9th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					,, ,		
4280		880	The 10th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4281	11TH OTHER ICD PROCEDURE CODE NOT	881	The 11th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
1.231	ON FILE	001	on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
	OIT TIEL		code.		use this code for claims		procedure code(s).
			code.				
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4282	12TH OTHER ICD PROCEDURE CODE NOT	882	The 12th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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4202	ACTUATURE ICE PROCEDURE CORE NOT	000	The 42th Other ICD Breed has Code is set	4.6	Claim/agains la de information au ha	NAC7	National discountries of the control
4283	13TH OTHER ICD PROCEDURE CODE NOT ON FILE	003	The 13th Other ICD Procedure Code is not on file or invalid. Correct the procedure	10	Claim/service lacks information or has submission/billing error(s). Usage: Do not	M67	Missing/incomplete/invalid other procedure code(s).
	ONTILE		code.		use this code for claims		procedure code(s).
			code.				
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4284	14TH OTHER ICD PROCEDURE CODE NOT	884	The 14th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4285	15TH OTHER ICD PROCEDURE CODE NOT	885	The 15th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
	0		code.		use this code for claims		p. 00000. 0 0000(3).
			Couc.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4286	16TH OTHER ICD PROCEDURE CODE NOT	886	The 16th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
1007		007	71 471 01 100 0	4.0		1467	
4287	17TH OTHER ICD PROCEDURE CODE NOT	887	The 17th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4288	18TH OTHER ICD PROCEDURE CODE NOT	888	The 18th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mormation KET), ii present.		
1000		lana	TI 401 01 100 0	4.0		1467	
4289	19TH OTHER ICD PROCEDURE CODE NOT	889	The 19th Other ICD Procedure Code is not	16	T	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
	1				least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4290	20TH OTHER ICD PROCEDURE CODE NOT	890	The 20th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation KET J, it present.		
4291		891	The 21st Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4292	22ND OTHER ICD PROCEDURE CODE NOT	892	The 22nd Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
.232	ON FILE	032	on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
	ONTICE		code.		use this code for claims		procedure code(s).
			code.		attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4293	23RD OTHER ICD PROCEDURE CODE NOT	893	The 23rd Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
]			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4294	24TH OTHER ICD PROCEDURE CODE NOT	894	The 24th Other ICD Procedure Code is not	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	ON FILE		on file or invalid. Correct the procedure		submission/billing error(s). Usage: Do not		procedure code(s).
			code.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information KEF), it present.		
4295	13TH OTHER ICD PROCEDURE NOT	2313	The 13th Other ICD Procedure is not a	16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other
	COVERED		Covered Benefit.		submission/billing error(s). Usage: Do not		procedure code(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4311	PRIMARY HDR DIAG RSTCN FOR PROC	1519	The First Diagnosis Code is invalid for the	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	BILLING RULE		Procedure Code.		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		-
					(loop 2110 Service Payment Information		
					REF), if present.		
4312	PRIMARY DTL DIAG RSTCN FOR PROC	1519	The First Diagnosis Code is invalid for the	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	BILLING RULE		Procedure Code.		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4313	SECONDARY DTL DIAG RSTCN FOR PROC	1517	One or more of the Secondary Diagnosis	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
1	BILLING RULE	[Code(s) are invalid for the Procedure	[procedure. Usage: Refer to the 835		diagnosis.
	5.22		Code.		Healthcare Policy Identification Segment		3.05.103.01
					(loop 2110 Service Payment Information		
					REF), if present.		
4314	CLAIM TYPE RESTRICTION ON DIAG CVG	1554	The claim type and diagnosis code	16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or
	RULE		submitted are not payable.		submission/billing error(s). Usage: Do not		condition.
			are not payout.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
			1		Segment (loop 2110 Service Payment		1
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4315	ANY HDR DIAG RSTCN FOR PROC BILLING	80	PROCEDURE CODE NOT PAYABLE WITH	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	RULE		DIAGNOSIS ENTERED		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4316	ANY DTL DIAG RSTCN FOR PROC BILLING	80	PROCEDURE CODE NOT PAYABLE WITH	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	RULE		DIAGNOSIS ENTERED		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4318	PRIMARY HDR DIAG RESTRICTION ON ICD	1515	The Primary Diagnosis Code is invalid for	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	BILLING RULE		the ICD Procedure Code.		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4321	PRIMARY HDR DIAG RSTCN FOR REV CODE	1516	The Primary Diagnosis Code is invalid for	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	BILLING RULE		the Revenue Code.		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		J. Company of the com
					(loop 2110 Service Payment Information		
					REF), if present.		
4322	ANY HDR DIAG RSTCN FOR REV BILL RULE	1581	Diagnos(es) not allowable for the billed	96	Non-covered charge(s). At least one	N569	Not covered when performed for the
			Revenue Code.		Remark Code must be provided (may be		reported diagnosis.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment information KET J, ii present.		
4342	15TH DIAGNOSIS CODE NOT ON FILE	7337	The 14th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other
			(Institutional) is Invalid. Correct the		service reported.		diagnosis.
			diagnosis code				_
4343	16TH DIAGNOSIS CODE NOT ON FILE	7343	The 15th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
			(Institutional) is Invalid. Correct the		service reported.		condition.
			diagnosis code				
4344	17TH DIAGNOSIS CODE NOT ON FILE	7349	The 16th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
			(Institutional) is Invalid. Correct the		service reported.		condition.
			diagnosis code				
4345	18TH DIAGNOSIS CODE NOT ON FILE	7355	The 17th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M76	Missing/incomplete/invalid diagnosis or
15.15	10111 BIN IGHTOSIS GODE HOT ON THEE	7555	(Institutional) is Invalid. Correct the	1.0	service reported.		condition.
			diagnosis code		service reported.		Conditions
4346	19TH DIAGNOSIS CODE NOT ON FILE	7361	The 18th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other
	THE STATE OF THE S	1	(Institutional) is Invalid. Correct the	[service reported.	l	diagnosis.
			diagnosis code		service reported.		diagnosis.
4348	20TH DIAGNOSIS CODE NOT ON FILE	7367	The 19th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other
7370	25 TH DIAGNOSIS CODE NOT ON FILE	7.507	(Institutional) is Invalid. Correct the	140	service reported.	1110-1	diagnosis.
			diagnosis code		service reported.		uiagnosis.
4349	21ST DIAGNOSIS CODE NOT ON FILE	7373	The 20th Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other
4349	2131 DIAGNOSIS CODE NOT ON FILE	/3/3	_	140		IVIO4	Missing/incomplete/invalid other
			(Institutional) is Invalid. Correct the		service reported.		diagnosis.
		l	diagnosis code			l	

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4362	TYPE OF BILL RESTRICTION ON DIAG	229	The Type of Bill is not allowed for the	16	Claim/service lacks information or has	MA30	Missing/incomplete/invalid type of bill.
	BILLING RULE		service.		submission/billing error(s). Usage: Do not		
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4366	MEDICARE COINSURANCE GREATER THAN	3022	Both the Medicare allowed amount and	16	Claim/service lacks information or has	N480	Incomplete/invalid Explanation of Benefits
	MEDICARE PAID AM		Medicare paid amount and one or more		submission/billing error(s). Usage: Do not		(Coordination of Benefits or Medicare
			of the following amounts: deductible,		use this code for claims		Secondary Payer).
			coinsurance and/or copayment, on all		attachment(s)/other documentation. At		
			crossover claims. Claims will be denied if		least one Remark Code must be provided		
			the Medicare payments are not indicated		(may be comprised of either the NCPDP		
			on the claim at the detail level.		Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4367	MEDICARE COINSURANCE GREATER THAN	2022	Both the Medicare allowed amount and	16	Claim/service lacks information or has	N480	Incomplete/invalid Explanation of Benefits
4307	MEDICARE PAID AM	3022	Medicare paid amount and one or more	10	submission/billing error(s). Usage: Do not	14400	(Coordination of Benefits or Medicare
	WEDICARE LAID AW		of the following amounts: deductible,		use this code for claims		Secondary Payer).
			coinsurance and/or copayment, on all		attachment(s)/other documentation. At		Secondary rayery.
			crossover claims. Claims will be denied if		least one Remark Code must be provided		
			the Medicare payments are not indicated		(may be comprised of either the NCPDP		
			on the claim at the detail level.		Reject Reason Code, or Remittance Advice		
			on the claim at the detail level.		Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					information REF), ii present.		
4370	22ND DIAGNOSIS CODE NOT ON FILE	7379	The 21st Other Diagnosis Code	146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other
			(Institutional) is Invalid. Correct the		service reported.		diagnosis.
			diagnosis code				
4371		1379	The service are not covered for the	16	Claim/service lacks information or has	N34	Incorrect claim form/format for this
	RULE		client's benefit plan when billed on this		submission/billing error(s). Usage: Do not		service.
			claim type.		use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4372	SECONDARY HDR DIAG RSTCN FOR PROC BILLING RULE	1517	One or more of the Secondary Diagnosis Code(s) are invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4374	CLAIM TYPE RESTRICTION ON REV CODE CVG RULE	1379	The service are not covered for the client's benefit plan when billed on this claim type.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.
4379	23RD DIAGNOSIS CODE NOT ON FILE	7385	The 22nd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4380	24TH DIAGNOSIS CODE NOT ON FILE	7391	The 23rd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4381	25TH DIAGNOSIS CODE NOT ON FILE	7397	The 24th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4711	AGE RESTRICTION ON DIAG BILLING RULE	1518	Diagnosis Code is restricted by member age.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4712	AGE RESTRICTION ON REVENUE CODE BILLING RULE	4712	Revenue Code is restricted by member age.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4714	AGE RESTRICTION ON PROC BILLING RULE	184	Procedure Code is restricted by member age.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4724	ANY HDR DIAG RSTCN FOR ICD CVG RULE	1221	Diagnosis Restriction on ICD Coverage Rule	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4731	ANY DTL DIAG RSTCN FOR PROC CVG RULE	1377	The Procedure Code has Diagnosis restrictions.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4733	ANY HDR DIAG RSTCN FOR REV CVG RULE	407	None of the submitted diagnoses on the	11	The diagnosis is inconsistent with the		
			claim are covered for this revenue code.		procedure. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4741	PROC ON ANY DTL RESTRICTION ON	1567	Procedure on any detail restriction on	96	Non-covered charge(s). At least one	N431	Not covered with this procedure.
	PROCEDURE CVG RULE		procedure coverage rule.		Remark Code must be provided (may be		
			Freezes a servinge reserv		comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment information KEr), it present.		
4742	PRIMARY HDR DIAG RSTCN FOR PROC	1519	The First Diagnosis Code is invalid for the	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	CVG RULE		Procedure Code.		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4743	SECONDARY DTL DIAG RSTCN FOR PROC	1517	One or more of the Secondary Diagnosis	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	CVG RULE		Code(s) are invalid for the Procedure		procedure. Usage: Refer to the 835		diagnosis.
	CTO NOLL		Code.		Healthcare Policy Identification Segment		diagnosis.
			couc.		(loop 2110 Service Payment Information		
					REF), if present.		
4744	SECONDARY HDR DIAG RSTCN FOR PROC	1520	The Secondary Diagnosis Code is	11	The diagnosis is inconsistent with the		
4/44	CVG RULE	1320	inappropriate for the Procedure Code.	11	procedure. Usage: Refer to the 835		
	CVG ROLE		mappropriate for the Procedure Code.		F =		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4745	ANY HDR DIAG RSTCN FOR PROC CVG	406	None of the submitted diagnoses on the	11	The diagnosis is inconsistent with the		
	RULE		claim are covered for this procedure code.		procedure. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4746	FIRST DTL DIAG RSTRCN FOR PROC CVG	1519	The First Diagnosis Code is invalid for the	11	The diagnosis is inconsistent with the	M64	Missing/incomplete/invalid other
	RULE		Procedure Code.		procedure. Usage: Refer to the 835		diagnosis.
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4747	PRIMARY HDR DIAG RESTRICTION ON	1568	Revenue code is not covered with this	11	The diagnosis is inconsistent with the		
	REVENUE CVG RULE	1	principal header diagnosis.		procedure. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
4748	CURR BENEFIT PLAN RSTCN ON PROC	1544	The service is not reimbursable for the	204	This service/equipment/drug is not	N130	Consult plan benefit
-	BILLING RULE		member's benefit plan.	-	covered under the patients current		documents/guidelines for information
			Societie plani		benefit plan		about restrictions for this service.
4749	1ST DTL DIAGNOSIS RESTRICTION ON	1239	The Procedure Code has Diagnosis	96	Non-covered charge(s). At least one	N569	Not covered when performed for the
	PROC BILLING RULE		restrictions.		Remark Code must be provided (may be		reported diagnosis.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
		Ì			Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
		1			Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4751	TYPE OF BILL RESTRICTION ON REV CODE BILLING RULE	229	The Type of Bill is not allowed for the service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
4752	TYPE OF BILL CTBF RESTRICTION ON DIAG BILLING RULE	1556	Type of Bill is not allowable for the Billed Diagnosis.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4753	TYPE OF BILL CTBF RESTRICTION ON PROC BILLING RULE	1592	CPT/HCPCS codes are not reimbursable on this type of bill.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4754	TYPE OF BILL RESTRICTION ON PROC BILLING RULE	1592	CPT/HCPCS codes are not reimbursable on this type of bill.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4755	TYPE OF BILL CTBF RSTCN ON REV CODE BILLING RULE	1548	TYPE OF BILL RESTRICTION ON PROC BILLING RULE CPT/HCPCS codes are not reimbursable on this type of bill.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4756	TYPE OF BILL CTBF RSTCN ON PROC REIMB RULE	1572	Procedure code is not reimbursable for this type of bill.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4757	TYPE OF BILL CTBF RSTCN ON REV CODE REIMB RULE	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4758	BILLING PT/PS RSTCN ON PROC COVERAGE RULE	1551	Billing Provider's PT/PS not allowed to bill the procedure under the Client's Benefit Plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
4759	PROV CONTRACT RSTCN ON PROC COVERAGE RULE	1574	BILLING PROVIDER TYPE/SPECIALTY RESTRICTION ON PROCEDURE COVERAGE RULE.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4761	CONTRACT RSTCN ON REV CODE CVG	1580	Revenue code not covered under	96	Non-covered charge(s). At least one	N130	Consult plan benefit
	RULE		provider?s contract.		Remark Code must be provided (may be		documents/guidelines for information
					comprised of either the NCPDP Reject		about restrictions for this service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4765	NO CVG RULE FOR SURGICAL PROCEDURE	4200	ICD Procedure Code not covered for the	16	Claim/service lacks information or has	M20	Missing/incomplete/invalid HCPCS.
4705	INO CVG ROLE FOR SURGICAL PROCEDURE	1360	date of service.	10	*	IVIZU	ivissing/incomplete/invalid HCPCs.
			date of service.		submission/billing error(s). Usage: Do not		
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4768	MEDICAL REVIEW FOR SURGICAL	1103	This surgical procedure requires medical	96	Non-covered charge(s). At least one	N35	Program integrity/utilization review
4700	PROCEDURE CVG RULE	1105	review.	90	Remark Code must be provided (may be	INOO	decision.
	PROCEDORE CVG ROLE		review.		comprised of either the NCPDP Reject		decision.
					1		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4776	BILLING PT/PS RESTRICTION ON DIAG	1555	BILLING PROVIDER TYPE/SPECIALTY NOT	96	Non-covered charge(s). At least one	N569	Not covered when performed for the
	BILLING RULE		ALLOWABLE FOR BILLED DIAGNOSIS.		Remark Code must be provided (may be		reported diagnosis.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					aymene information ker j, ii present.		
4780	REVENUE CODE RESTRICTION ON PROC	1116	The Revenue Code requires an	199	Revenue code and Procedure code do not	N657	This should be billed with the appropriate
	BILLING RULE		appropriate corresponding Procedure		match.		code for these services.
4700		4707	Code.				
4790	EMERGENCY INDICATOR RSTCN ON PROC	1727	Emergency Indicator Restriction on billed	40	Charges do not meet qualifications for		
	BILLING RULE		procedure.		emergent/urgent care. Usage: Refer to		
					the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
4791	EMERGENCY INDICATOR RSTCN ON PROC	1728	Emergency Indicator Restriction on	40	Charges do not meet qualifications for		
	CVG RULE		covered procedure.		emergent/urgent care. Usage: Refer to		
		1			the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4792	ADMIT TYPE RESTRICTION ON REVENUE CODE CVG RULE	1577	Revenue code is not covered with this type of admission.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA41	Missing/incomplete/invalid admission type.
4801	NO BILLING RULE FOR PROCEDURE	116	Services Not Covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
4802	NO BILLING RULE FOR DIAGNOSIS	558	The service requested is not allowable for the Diagnosis indicated.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4804	NO BILLING RULE FOR REVENUE CODE	116	Services Not Covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
4804	NO BILLING RULE FOR REVENUE CODE	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4811	MEDICAL REVIEW FOR PROC BILLING RULE	241	Benefit Determined Per Medical Review	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4812	MEDICAL REVIEW FOR DIAG BILLING RULE	241	Benefit Determined Per Medical Review	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4813	MEDICAL REVIEW FOR PROC BILLING RULE	241	Benefit Determined Per Medical Review	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4820	Aid Code Not Eligible for Procedure	4820	Recipient's aid code is not eligible for procedure code	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4821	PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE	1279	Procedure not payable for Place of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
4861	CLAIM REGION RESTRICTION ON DIAGNOSIS CVG RULE	1564	Diagnosis is not covered with this claim region	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4862	CLAIM REGION RESTRICTION ON ICD PROC CVG RULE	1566	ICD procedure is not covered with this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4863	CLAIM REGION RESTRICTION ON ICD PROC BILLING RULE	1566	ICD procedure is not covered with this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be	N431	Not covered with this procedure.
					comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4865	CLAIM REGION RESTRICTION ON PROC BILLING RULE	1576	Procedure not covered for this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4867	CLAIM REGION RESTRICTION ON REV BILL RULE	1575	REVENUE CODE NOT COVERED FOR THIS CLAIM REGION.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N180	This item or service does not meet the criteria for the category under which it was billed.
4870	CLAIM TYPE RESTRICTION ON ICD PROC CVG RULE	1565	ICD procedure is not covered with this claim type.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4871	CLAIM TYPE RESTRICTION ON PROC BILLING RULE	1521	Procedure Code is not billable on this Claim Type.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.
4872	CLAIM TYPE RESTRICTION ON DIAG BILLING RULE	1545	The diagnosis code is not reimbursable for the claim type submitted.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4874	CLAIM TYPE RESTRICTION ON REV CODE	770	The Revenue Code Cannot Be Billed on	16	Claim/service lacks information or has	N34	Incorrect claim form/format for this
	BILLING RULE		this Claim Type.		submission/billing error(s). Usage: Do not		service.
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					mornation ner // n presenti		
4876	CLAIM TYPE RESTRICTION ON ICD BILLING	1565	ICD procedure is not covered with this	96	Non-covered charge(s). At least one	N431	Not covered with this procedure.
	RULE		claim type.		Remark Code must be provided (may be		
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4901	BILLING PROV GEO LOC RSTCN ON REV	4901	Billing Provider Geographic Location	96	Non-covered charge(s). At least one	M97	Not paid to practitioner when provided to
1.00	REIMB RULE		Restriction on Revenue Reimbursement		Remark Code must be provided (may be		patient in this place of service. Payment
	NEIVIS NOTE		Rule.		comprised of either the NCPDP Reject		included in the reimbursement issued the
			Traine.		Reason Code, or Remittance Advice		facility.
					Remark Code that is not an ALERT.) Usage:		industry.
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					rayment mormation KE1 J, ii present.		
4902	CLIENT GEO LOC RSTCN ON REV REIMB	4902	Client Geographic Location Restriction on	96	Non-covered charge(s). At least one	M97	Not paid to practitioner when provided to
	RULE		Revenue Reimbursement Rule.		Remark Code must be provided (may be		patient in this place of service. Payment
					comprised of either the NCPDP Reject		included in the reimbursement issued the
					Reason Code, or Remittance Advice		facility.
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4903	PROC DOES NOT MATCH PROC GROUP ON	4903	Procedure is not covered. (Does not	96	Non-covered charge(s). At least one	N431	Not covered with this procedure.
	PROC CVG RULE		match Procedure Group on Procedure		Remark Code must be provided (may be		
			Coverage Rule)		comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
1					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4944	GENDER RESTRICTION FOR ICD BILLING	1281	ICD Procedure Code billed is not	7	The procedure/revenue code is		
.5 17	RULE	1	appropriate for member's gender.	ľ	inconsistent with the patients gender.		
			app. spriate for member a gender.		Usage: Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
					aymene information KE1), ii present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4963	GENDER RESTRICTION FOR PROC BILLING	185	Procedure Code billed is not appropriate	7	The procedure/revenue code is		
	RULE		for member's gender.		inconsistent with the patients gender.		
					Usage: Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
4975	BENEFIT PLAN RESTRICTION FOR REV	698	Service is not billable with client's Benefit	204	This service/equipment/drug is not		
	BILLING RULE		Plan.		covered under the patients current		
1005	OURD DEVISER BY AN ESTAN ON BEY CORE	500	6	204	benefit plan		
4985	CURR BENEFIT PLAN RSTCN ON REV CODE	698	Service is not billable with client's Benefit	204	This service/equipment/drug is not		
	BILLING RULE		Plan.		covered under the patients current		
					benefit plan		
5000	EXACT DUPLICATE: INPATIENT TO	5000	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
	INPATIENT		CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5001	POSSIBLE DUPLICATE: INPATIENT TO	5001	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	INPATIENT		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5002	POSS CONFLICT: PT44 (SWING BED ACUTE	5002	CLAIM/DETAIL CONFLICTS WITH A	97		M86	Service denied because payment already
	HOSP) VS OTHE		PREVIOUSLY PAID SERVICE ON SAME OR		the payment/allowance for another		made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE		service/procedure that has already been		set time frame.
					adjudicated. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
5003	POSS CONFLICT: PT13 (PSYCH HOSP	5003	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	INPAT) VS OTHERS		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE				set time frame.
5003	POSS CONFLICT: PT13 (PSYCH HOSP	8223	Services included in Inpatient Stay	96	Non-covered charge(s). At least one	M2	Not paid separately when the patient is an
	INPAT) VS OTHERS				Remark Code must be provided (may be		inpatient.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
5004	POSS CONFLICT: PT63 (RTC) VS OTHERS	5004	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
3004	POSS CONFEICT. PTOS (KTC) VS OTHERS	3004	PREVIOUSLY PAID SERVICE ON SAME OR	620		IVIOU	made for same/similar procedure within
					furnished by another provider.		·
5004	POSS CONFLICT: PT63 (RTC) VS OTHERS	8223	OVERLAPPING DATE OF SERVICE Services included in Inpatient Stay	96	Non-covered charge(s). At least one	M2	set time frame. Not paid separately when the patient is an
3004	POSS CONFEICT. PTOS (KTC) VS OTHERS	0223	Services included in inpatient stay	90	= ::	IVIZ	
					Remark Code must be provided (may be		inpatient.
					comprised of either the NCPDP Reject		
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
5005	POSS CON: PT56 MED RHB/LTAC SPC	5005	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	HOSP VS OTHR FCLTY		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE		,		set time frame.
5006	POSS DUPE: INPAT TO OUTPA AND OUTPA	5006	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
5006	POSS DUPE: INPAT TO OUTPA AND OUTPA TO INPAT	5006	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5007	POSSIBLE DUPLICATE: INPATIENT VS	5007	POSSIBLE DUPLICATE OF A PREVIOUSLY	B13	Previously paid. Payment for this	M86	Service denied because payment already
	MEDICARE		PAID CLAIM/DETAIL		claim/service may have been provided in		made for same/similar procedure within
					a previous payment.		set time frame.
5008	EXACT DUPE: INPAT CROSSOVER TO INPAT	5008	INPATIENT CROSSOVER-EXACT DUPLICATE	18	Exact duplicate claim/service (Use only		
	CROSSOVER		OF A PREVIOUSLY PAID CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
5009	POSS DUPE: INPAT CROSSOVER TO INPAT	E000	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	requires CO) Procedure/service was partially or fully	M86	Service denied because payment already
3009	CROSSOVER	3009	PAID CLAIM/DETAIL	620	furnished by another provider.	IVIOU	made for same/similar procedure within
	CNOSSOVEN		PAID CLAIM/DETAIL		idinished by another provider.		set time frame.
5010	EXACT DUPLICATE: OUTPATIENT TO	5010	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
	OUTPATIENT		CLAIM/DETAIL		with Group Code OA except where state		
			·		workers compensation regulations		
					requires CO)		
5011	POSSIBLE DUPLICATE: OUTPATIENT TO	5011	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	OUTPATIENT		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5012	POSSIBLE DUPLICATE: OUTPATIENT VS	5012	POSSIBLE DUPLICATE OF A PREVIOUSLY	B13	Previously paid. Payment for this	M86	Service denied because payment already
	MEDICARE		PAID CLAIM/DETAIL		claim/service may have been provided in		made for same/similar procedure within
5040	2000 2005 27 40 40 27 40 40 27 40 40	5040	DOSCIDLE BURLONES OF A PREMIONS	222	a previous payment.		set time frame.
5013	POSS DUPE: PT 10 VS PT 46 AND PT 46 VS PT 10	5013	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	P1 10		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within set time frame.
5015	POSS CON:OUTPA TO OUTP XO AND OUTP	5015	CLAIM/DETAIL CONFLICTS WITH A	B13	Previously paid. Payment for this	M86	Service denied because payment already
3013	XO TO OUTP-MODI	3013	PREVIOUSLY PAID SERVICE ON SAME OR	B13	claim/service may have been provided in	IVIOU	made for same/similar procedure within
	no re con mes.		OVERLAPPING DATE OF SERVICE		a previous payment.		set time frame.
5016	EXACT DUPLICATE: HOME HEALTH TO	5016	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
	HOME HEALTH		CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5017	POSSIBLE DUPLICATE: HOME HEALTH TO	5017	POSSIBLE DUPLICATE OF A PREVIOUSLY	B13	Previously paid. Payment for this	M86	Service denied because payment already
	HOME HEALTH		PAID CLAIM/DETAIL		claim/service may have been provided in		made for same/similar procedure within
					a previous payment.		set time frame.
5018	EXACT DUPE: NURSING FACILITY TO	5018	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
	NURSING FACILITY		CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
5019	POSS DUPE: NURSING FACILITY TO	5019	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	requires CO)	M86	Comittee desired because manner at almost in
5019	NURSING FACILITY	5019	PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	IVI86	Service denied because payment already made for same/similar procedure within
	NORSING FACILITY		PAID CLAIM/DETAIL		rumished by another provider.		set time frame.
5021	EXACT DUPLICATE: ICIID FACILITY TO ICIID	5021	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		set time name.
5021	FACILITY	3021	CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5022	POSS DUPE: ICIID FACILITY TO ICIID	5022	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	FACILITY		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5023	POSS DUPE: INPATIENT VS ADULT DAY	5023	POSSIBLE DUPLICATE OF A PREVIOUSLY	97	The benefit for this service is included in	M86	Service denied because payment already
	HEALTH CARE		PAID CLAIM/DETAIL		the payment/allowance for another		made for same/similar procedure within
					service/procedure that has already been		set time frame.
					adjudicated. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
5024	INPATIENT/OUTPATIENT CONFLICT	5024	INPATIENT/OUTPATIENT SERVICES DATE	B13	Previously paid. Payment for this	M86	Service denied because payment already
3024	INFAMENT/OUTPATIENT CONFEICT	3024	CONFLICT	013	claim/service may have been provided in	IVIOU	made for same/similar procedure within
			55 561		a previous payment.		set time frame.
l	1	1	L	l	a previous payment.	l	sec and name.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5028	EXACT DUPLICATE - OUTPA XOVER TO	5028	EXACT DUPLICATE - OUTPATIENT XOVER	18	Exact duplicate claim/service (Use only		
	OUTPA XOVER		TO OUTPATIENT XOVER		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5033	EXACT DUPLICATE: PCS TO PCS	5033	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
			CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5034	POSSIBLE DUPLICATE: PCS TO PCS	5034	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
			PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5035	EXACT DUPLICATE: PRACTITIONER TO	5035	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
	PRACTITIONER		CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5036	POSSIBLE DUPLICATE: PRACTITIONER TO	5036	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	PRACTITIONER		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5037	POSS DUPE: PRACT TO PRACT -	5037	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	RADIOLOGY		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5038	POSS DUPE: PT20 PHYS MD OSTEOPATH	5038	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	DO VS OTHERS		PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5039	POSSIBLE DUPLICATE: ASC VS OTHERS	5039	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
			PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5040	POSSIBLE DUPLICATE: PRACTITIONER VS	5040	POSSIBLE DUPLICATE OF A PREVIOUSLY	97	The benefit for this service is included in	M86	Service denied because payment already
	MEDICARE		PAID CLAIM/DETAIL		the payment/allowance for another		made for same/similar procedure within
					service/procedure that has already been		set time frame.
					adjudicated. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
5041	POSS CON: PT48 HCBS VS INP/LTC	5041	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
			PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE				set time frame.
5042	POSS CON: PT38 WVR FOR IID AND	5042	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	RELATED COND VS OTH		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE				set time frame.
5043	POSS CON: PT14 BEHOP TREATMENT VS	5043	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	OTHERS		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE				set time frame.
5044	POSS CON: PROVIDER TYPE 54 (TCM) VS	5044	CLAIM/DETAIL CONFLICTS WITH A	97	The benefit for this service is included in	M86	Service denied because payment already
	OTHERS		PREVIOUSLY PAID SERVICE ON SAME OR		the payment/allowance for another]	made for same/similar procedure within
			OVERLAPPING DATE OF SERVICE		service/procedure that has already been		set time frame.
					adjudicated. Usage: Refer to the 835		
					Healthcare Policy Identification Segment]	
					(loop 2110 Service Payment Information		
					REF), if present.		
5045	POSS CON: PT26 PSYCHOLOGIST VS	5045	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	OTHERS		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.	1	made for same/similar procedure within
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5046	EXACT DUPLICATE: LAB TO LAB	5046	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5047	POSSIBLE DUPLICATE: LAB TO LAB	5047	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5048	EXACT DUPLICATE: TRANSPORTATION TO TRANSPORTATION	5048	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5049	POSS DUPE: TRANSPORTATION TO TRANSPORTATION	5049	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5050	POSS DUPE: INP vs. Nursing Facility vs. ICI	5050	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
5051	POSS DUPE: INP VS OUTP	5051	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5052	EXACT DUPE: PROF XOVER TO PROF XOVER	5052	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5054	POSS DUPE: HH VS INP/NF & PCS VS INP/NF	5054	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5056	SAME PROCEDURE DIFF MODS SAME DAY	5056	SAME PROCEDURE/DIFFERENT MODIFIER NOT ALLOWED SAME DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
5057	POSSIBLE CONFLICT: NURSING FACILITY VS HOSPICE	5057	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5057	POSSIBLE CONFLICT: NURSING FACILITY VS HOSPICE	8200	RECIPIENT'S ELIGIBILITY WAS UPDATED AFTER CLAIM PAID	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5058	POSS CONFLICT: PROVIDER TYPE 57 VS	5058	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	OTHERS		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DA				set time frame.
5059	POSS CONFLICT: PROV TYPE 39 VS PROV	5059	CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	TYPE 57		PREVIOUSLY PAID SERVICE ON SAME OR		furnished by another provider.		made for same/similar procedure within
			OVERLAPPING DA				set time frame.
5064	EXACT DUPLICATE: DENTAL TO DENTAL	5064	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		
			CLAIM/DETAIL		with Group Code OA except where state		
					workers compensation regulations		
					requires CO)		
5065	POSSIBLE DUPLICATE: DENTAL TO DENTAL	. 5065	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
			PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
							set time frame.
5066	POSSIBLE DUPLICATE OP HOSPICE TO OP	5066	POSSIBLE DUPLICATE OP HOSPICE TO OP	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	HOSPICE CLAIM		HOSPICE CLAIM DETAIL LINE		furnished by another provider.		made for same/similar procedure within
							set time frame.
5068	ASC AND PROFESSIONAL CLAIMS DO NOT	5068	ASC MATCH TO PROFESSIONAL	59	Processed based on multiple or		
	MATCH				concurrent procedure rules. (For example		
					multiple surgery or diagnostic imaging,		
					concurrent anesthesia.) Usage: Refer to		
					the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
5069	WELL CHECK & SICK VISITS BILLED ON THE	5069	WELL CHECK & SICK VISITS BILLED ON THE	119	Benefit maximum for this time period or	N130	Consult plan benefit
	SAME DAY		SAME DAY		occurrence has been reached.		documents/guidelines for information
							about restrictions for this service.
5070	POSS DUPE: INP VS NF OR ICIID	5070	DOCCIDLE DUDUCATE OF A DREWOUGH	B13	Danierak, asid Danierak faratkia		
5070	POSS DUPE: INP VS NF OR ICID	5070	POSSIBLE DUPLICATE OF A PREVIOUSLY	B13	Previously paid. Payment for this		
			PAID CLAIM/DETAIL		claim/service may have been provided in		
5071	DOCC COM- DTEC MED DELIAD LTAC CDEC	5005	CLAIRA/DETAIL CONFLICTS MUTU A	B20	a previous payment.	1400	Comittee desired because on the large desired
50/1	POSS CON: PT56 MED REHAB LTAC SPEC	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR	B20	Procedure/service was partially or fully	M86	Service denied because payment already
	HOSP VS PROF				furnished by another provider.		made for same/similar procedure within
5072	POSS CON: PT56 MED REHAB VS PT33	5005	OVERLAPPING DATE OF SERVICE CLAIM/DETAIL CONFLICTS WITH A	B20	Procedure/service was partially or fully	M86	set time frame. Service denied because payment already
5072	DME	5005	PREVIOUSLY PAID SERVICE ON SAME OR	620		IVIOO	1 1
	DIVIE				furnished by another provider.		made for same/similar procedure within set time frame.
5073	POSS DUPLICATE IP HOSPICE TO IP	5073	OVERLAPPING DATE OF SERVICE CLAIM/DETAIL CONFLICTS WITH A	119	Benefit maximum for this time period or	N130	
50/3	HOSPICE	50/3		119	occurrence has been reached.	N130	Consult plan benefit
	HOSPICE		PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE		occurrence has been reached.		documents/guidelines for information
			OVERLAPPING DATE OF SERVICE				about restrictions for this service.
5076	EXACT DUPLICATE: NON-IHS ENCOUNTERS	5076	EXACT DUPLICATE OF A PREVIOUSLY PAID	18	Exact duplicate claim/service (Use only		1
3070	EARCH DOFFICATE, NON-INS ENCOUNTERS	, 30, 0	CLAIM/DETAIL	10	with Group Code OA except where state		
			CLAINI, DETAIL		workers compensation regulations		
					requires CO)		
5077	EXACT DUPLICATE: HOSPICE OUTPATIENT	5077	Exact Duplicate: Hospice Outpatient to	18	Exact duplicate claim/service (Use only		
5077	TO HOSPICE OUT	3077	Hospice Outpatient Claim Detail Lines	10	with Group Code OA except where state		
	TO HOSFICE OUT		1103pice Outpatient Claim Detail Lilles		workers compensation regulations		
					requires CO)		
5081	IP VISIT SAME PROV SPECIALTY SAME DAY	5038	POSSIBLE DUPLICATE OF A PREVIOUSLY	B20	Procedure/service was partially or fully	M86	Service denied because payment already
5551	NOT ALLOWED	3330	PAID CLAIM/DETAIL		furnished by another provider.		made for same/similar procedure within
	NOT ALLOWED		FAID CLAIM/DETAIL		Turnished by another provider.		The state of the s
				l		l	set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5093	NCCI PTP CONFLICT PRACT MODS CANT	5093	NCCI PTP conflict, practitioner, outpatient,	236	This procedure or procedure/modifier		
	BYPASS		DME - modifiers cannot solve		combination is not compatible with		
					another procedure or procedure/modifier		
					combination provided on the same day		
					according to the National Correct Coding		
					Initiative or workers compensation state		
					regulations/ fee schedule requirements.		
5094	NCCI PTP CONFLICT PRACTITIONER MOD	5094	NCCI PTP conflict, practitioner, outpatient,	236	This procedure or procedure/modifier		
3034	BYPASS POSSBL	3034	DME - modifiers bypass possible	250	combination is not compatible with		
	D11 A33 1 033BE		DIVIE Modifiers bypass possible		another procedure or procedure/modifier		
					combination provided on the same day		
					according to the National Correct Coding		
					Initiative or workers compensation state		
					regulations/ fee schedule requirements.		
					regulationsy ree senedule requirements.		
5095	NCCI PTP CONFLICT OUTPATIENT MODS	5093	NCCI PTP conflict, practitioner, outpatient,	236	This procedure or procedure/modifier		
	CANT BYPASS		DME - modifiers cannot solve		combination is not compatible with		
					another procedure or procedure/modifier		
					combination provided on the same day		
					according to the National Correct Coding		
					Initiative or workers compensation state		
					regulations/ fee schedule requirements.		
5096	NCCI PTP CONFLICT OUTPATIENT MOD	5094	NCCI PTP conflict, practitioner, outpatient,	236	This procedure or procedure/modifier		
	BYPASS POSSIBLE		DME - modifiers bypass possible		combination is not compatible with		
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		another procedure or procedure/modifier		
					combination provided on the same day		
					according to the National Correct Coding		
					Initiative or workers compensation state		
					regulations/ fee schedule requirements.		
5007		5000	LICE PTD GILL IN INC.	225	1 /		
5097	NCCI PTP CONFLICT DME MODS CANT	5093	NCCI PTP conflict, practitioner, outpatient,	230	This procedure or procedure/modifier		
	BYPASS		DME - modifiers cannot solve		combination is not compatible with		
					another procedure or procedure/modifier		
					combination provided on the same day		
					according to the National Correct Coding		
					Initiative or workers compensation state		
					regulations/ fee schedule requirements.		
5098	NCCI PTP CONFLICT DME MOD BYPASS	5094	NCCI PTP conflict, practitioner, outpatient,	236	This procedure or procedure/modifier		
	POSSIBLE		DME - modifiers bypass possible		combination is not compatible with		
					another procedure or procedure/modifier		
					combination provided on the same day		
					according to the National Correct Coding		
					Initiative or workers compensation state		
					regulations/ fee schedule requirements.		
<u> </u>							

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5099	NCCI PTP CONFLICT PAY CURRENT- REPROCESS HISTORY	5099	Previous paid service on same day to be recouped per National Correct Coding Initiative (NCCI) processing	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.
5212	CASH ADJ - SUBTOTAL OF PAID AMOUNTS IS NEGATIVE	1676	Unable To Process Your Adjustment Request. Claim Can No Longer Be Adjusted. Contact Provider Services For Further Information.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
5248	EXACT DUPLICATE: TRANSPORTATION TO TRANSPORTATION	5048	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5249	POSS DUPE: TRANSPORTATION TO TRANSPORTATION	5049	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5300	ENCOUNTER DUPLICATE - INPATIENT	5300	ENCOUNTER DUPLICATE - INPATIENT	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5301	ENCOUNTER DUPLICATE - OUTPATIENT	5301	ENCOUNTER DUPLICATE - OUTPATIENT	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5302	ENCOUNTER DUPLICATE - PROFESSIONAL	5302	ENCOUNTER DUPLICATE - PROFESSIONAL	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N832	Duplicate occurrence code/occurrence span code.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5303	ENCOUNTER DUPLICATE - DENTAL	5303	ENCOUNTER DUPLICATE - DENTAL	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N832	Duplicate occurrence code/occurrence span code.
5304	ENCOUNTER DUPLICATE - PHARMACY	5304	ENCOUNTER DUPLICATE - PHARMACY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N832	Duplicate occurrence code/occurrence span code.
5305	ENCOUNTER DUPLICATE (NET CLAIMS)	5305	ENCOUNTER DUPLICATE (NET CLAIMS)	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5500	1 UNIT ALLOWED PER ROLLING YEAR	5500	ONE UNIT ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5501	1 UNIT ALLOWED PER ROLLING YEAR - PA OVERRIDE	5501	ONE UNIT ALLOWED PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5502	12 UNITS ALLOWED PER ROLLING YEAR	5502	TWELVE UNITS ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5503	12 UNITS PER ROLLING YEAR - PA OVERRIDE	5503	TWELVE UNITS PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5504	1 UNIT ALLOWED PER 90 ROLLING DAYS	5504	ONE UNIT ALLOWED PER NINETY ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5505	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5505	ONE UNIT ALLOWED PER ROLLING SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5506	1 UNIT ALLOWED PER 12 ROLLING MONTHS	5506	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5507	3 UNITS ALLOWED PER DAY, SAME CLAIM PA OVERRIDE	-5507	THREE UNITS ALLOWED PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5508	4 UNITS ALLOWED PER 60 ROLLING MONTHS	5508	FOUR UNITS ALLOWED PER 60 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5509	1 UNIT ALLOWED PER 11 ROLLING MONTHS	5509	ONE UNIT ALLOWED PER 11 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5510	1 UNIT ALLOWED PER LIFETIME	5510	ONE UNIT ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5511	4 UNITS ALLOWED PER LIFETIME	5511	FOUR UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5512	1 UNIT ALLOWED PER 3 ROLLING MONTHS	5512	ONE UNIT ALLOWED PER 3 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5513	3 UNITS ALLOWED PER 6 ROLLING MONTHS	5513	THREE UNITS ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5514	2 UNITS ALLOWED PER LIFETIME	5514	TWO UNITS ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5515	1 UNIT ALLOWED PER ROLLING MONTH	5515	ONE UNIT ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5516	6 UNITS ALLOWED PER 60 ROLLING MONTHS	5516	SIX UNITS ALLOWED PER SIXTY ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5517	2 UNITS ALLOWED PER 12 ROLLING MONTHS	5517	TWO UNITS ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5518	1 UNIT ALLOWED PER 60 ROLLING MNTHS - PA OVERRIDE	5518	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5519	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5519	ONE UNIT ALLOWED PER SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5520	1 UNIT ALLOWED PER 24 ROLLING MONTHS	5520	ONE UNIT ALLOWED PER TWENTY-FOUR ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5521	1 UNIT ALLOWED PER 12 ROLLING MONTHS - PA OVERRIDE	5521	ONE UNIT ALLOWED PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5522	2 UNITS ALLOWED PER 6 ROLLING MONTHS	5522	TWO UNITS ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5523	1 UNIT ALLOWED PER 12 ROLLING MONTHS	5523	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5524	1 UNIT ALLOWED PER 48 ROLLING MONTHS	5524	ONE UNIT ALLOWED PER FORTY-EIGHT ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5525	4 UNITS ALLOWED PER 36 ROLLING MONTHS	5525	FOUR UNITS ALLOWED PER THIRTY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5526	6 UNITS ALLOWED PER 96 ROLLING MONTHS	5526	SIX UNITS ALLOWED PER NINETY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5527	6 UNITS ALLOWED PER 12 ROLLING MONTHS-PA OVERRIDE	5527	SIX UNITS ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5528	1 UNIT ALLOWED PER 9 ROLLING MONTHS	5528	ONE UNIT ALLOWED PER 9 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5529	2 UNITS ALLOWED PER ROLLING MONTH	5529	TWO UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5530	1 UNIT ALLOWED PER 8 ROLLING MONTHS	5530	ONE UNIT ALLOWED PER 8 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5531	1 UNIT ALLOWED PER 9 ROLLING MONTHS	5531	ONE UNIT ALLOWED PER 9 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5532	4 UNITS ALLOWED PER 12 ROLLING MONTHS	5532	FOUR UNITS ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5533	1 UNIT ALLOWED PER LIFETIME	5533	ONE UNIT ALLOWED PER LIFETIME	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N117	This service is paid only once in a patients lifetime.
5534	16 UNITS ALLOWED PER ROLLING MONTH	5534	SIXTEEN UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5535	40 UNITS ALLOWED PER ROLLING MONTH PA OVERRIDE	-5535	FORTY UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5536	2 UNITS ALLOWED PER CALENDAR YEAR	5536	TWO UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5537	1 UNIT ALLOWED PER DAY	5537	ONE UNIT ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5538	32 UNITS ALLOWED PER DAY	5538	THIRTY-TWO UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5539	8 UNITS ALLOWED PER DAY	5539	EIGHT UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5540	2 UNITS ALLOWED PER CALENDAR YEAR	5540	TWO UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5541	8 UNITS ALLOWED PER DAY	5541	EIGHT UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5542	1 UNIT ALLOWED PER CALENDAR MONTH	5542	ONE UNIT ALLOWED PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5543	150 UNITS ALLOWED EVERY 12 ROLLING MONTHS	5543	ONE HUNDRED-FIFTY UNITS ALLOWED EVERY TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5544	1 UNIT ALLOWED PER 90 ROLLING DAYS - PA OVERRIDE	5544	ONE UNIT ALLOWED PER NINETY ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5545	186 UNITS ALLOWED PER ROLLING	5545	ONE HUNDRED EIGHTY-SIX UNITS	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTH - PA OVERRIDE		ALLOWED PER ROLLING MONTH		occurrence has been reached.		exceeds our acceptable maximum.
			WITHOUT PRIOR APPROVAL				
5546	100 UNITS ALLOWED PER ROLLING	5546	ONE HUNDRED UNITS ALLOWED PER	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTH - PA OVERRIDE		ROLLING MONTH WITHOUT PRIOR		occurrence has been reached.		exceeds our acceptable maximum.
			APPROVAL				
5547	300 UNITS ALLOWED PER 30 ROLLING	5547	THREE HUNDRED UNITS ALLOWED PER	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	DAYS-PA OVERRIDE		THIRTY ROLLING DAYS WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5548	6 UNITS ALLOWED PER CALENDAR YEAR -	EE40	SIX UNITS ALLOWED PER CALENDAR YEAR	110	Benefit maximum for this time period or	N640	Exceeds number/frequency
3346	PA OVERRIDE	3346	WITHOUT PRIOR APPROVAL	119	occurrence has been reached.	14040	approved/allowed within time period.
	TA OVERNIDE		WITHOUT FRIOR AFFROVAL		occurrence has been reached.		approved/anowed within time period.
5549	16 PER 365 DAYS, 8 PER NEXT 365 DAYS	5549	16 UTS 1ST ROL 365 DAYS 8 UTS EA SUB	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
33.3	PA OVERRIDE	33.3	ROLL 365 DAYS PCODES WITH 9 W/O PA	113	occurrence has been reached.	11502	exceeds our acceptable maximum.
	77.072		note sas sins i costs inin s inje in		becarrence has been reached.		execess our deceptable maximum
5551	2 UNITS ALLOWED PER ROLLING MONTH -	5551	TWO UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5552	3 UNITS ALLOWED PER ROLLING MONTH -	5552	THREE UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5553	4 UNITS ALLOWED PER ROLLING MONTH -	5553	FOUR UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5554	5 UNITS ALLOWED PER ROLLING MONTH -	5554	FIVE UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5555	6 UNITS ALLOWED PER ROLLING MONTH -	5555	SIX UNITS ALLOWED PER ROLLING	273	Coverage/program guidelines were	N362	The number of Days or Units of Service
	PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		exceeded.		exceeds our acceptable maximum.
5556	10 UNITS ALLOWED PER ROLLING MONTH	EEEE	TEN UNITS ALLOWED PER ROLLING	273	Coverage/program guidelines were	N362	The number of Days or Units of Service
3330	- PA OVERRIDE	3330	MONTH WITHOUT PRIOR APPROVAL	2/3	exceeded.	11/302	exceeds our acceptable maximum.
	- FA OVERRIDE		WONTH WITHOUT FRIOR AFFROVAL		exceeded.		exceeds our acceptable maximum.
5557	15 UNITS ALLOWED PER ROLLING MONTH	5557	FIFTEEN UNITS ALLOWED PER ROLLING	273	Coverage/program guidelines were	N362	The number of Days or Units of Service
3337	- PA OVERRIDE	3337	MONTH WITHOUT PRIOR APPROVAL	2,0	exceeded.	11502	exceeds our acceptable maximum.
5558	20 UNITS ALLOWED PER ROLLING MONTH	5558	TWENTY UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	- PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
							·
5559	30 UNITS ALLOWED PER ROLLING MONTH	5559	THIRTY UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	- PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5560	3 UNITS ALLOWED PER LIFETIME	5560	THREE UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been	N587	Policy benefits have been exhausted.
					reached for this service/benefit category.		
5564	2 111175 111 01175 050 10 001	5564		440	0 60 1 1 1	Naca.	T 1 10 10 11 11 15 15 15
5561	2 UNITS ALLOWED PER 12 ROLLING	5561	TWO UNITS ALLOWED PER TWELVE	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS		ROLLING MONTHS		occurrence has been reached.		exceeds our acceptable maximum.
5562	1 UNIT ALLOWED PER 36 ROLLING	5562	ONE UNIT ALLOWED PER THIRTY-SIX	119	Benefit maximum for this time period or	M86	Sorvice denied because naument already
3302	MONTHS - PA OVERRIDE	3302	ROLLING MONTHS WITHOUT PRIOR	113	occurrence has been reached.	IVIOU	Service denied because payment already made for same/similar procedure within
	MONTHS - FA OVERMIDE		APPROVAL		occurrence has been reached.		set time frame.
5563	1 UNIT ALLOWED PER 6 ROLLING	5563	ONE UNIT ALLOWED PER 6 ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
3303	MONTHS - PA OVERRIDE	3303	MONTHS WITHOUT PRIOR APPROVAL	1	occurrence has been reached.		exceeds our acceptable maximum.
	MONTHS TA OVERNIDE				securities deciredened.		execces our acceptable maximum.
5564	1 UNIT ALLOWED PER 24 ROLLING	5564	ONE UNIT ALLOWED PER TWENTY-FOUR	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS - PA OVERRIDE		ROLLING MONTHS WITHOUT PRIOR	ĺ	occurrence has been reached.		exceeds our acceptable maximum.
	INION I HS - PA OVERRIDE		ROLLING WICH THE WITHOUT PRICK		occurrence has been reached.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5565	31 UNITS ALLOWED PER ROLLING MONTH	5565	THIRTY-ONE UNITS ALLOWED PER	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	- PA OVERRIDE		ROLLING MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5566	60 UNITS ALLOWED PER ROLLING MONTH	5566	SIXTY UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	- PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5567	50 UNITS ALLOWED PER ROLLING MONTH	5567	FIFTY UNITS ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	- PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5568	4 UNITS ALLOWED PER CALENDAR YEAR -	5568	FOUR UNITS ALLOWED PER CALENDAR	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		YEAR WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5569	2 UNITS ALLOWED PER CALENDAR YEAR -	5569	TWO UNITS ALLOWED PER CALENDAR	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		YEAR WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5570	12 UNITS ALLOWED PER 12 ROLLING	5570	TWELVE UNITS ALLOWED PER TWELVE	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS-PA OVERRIDE		ROLLING MONTHS WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5571	1 UNIT ALLOWED PER 6 ROLLING	5571	ONE UNIT ALLOWED PER 6 ROLLING	119	Benefit maximum for this time period or	M86	Service denied because payment already
	MONTHS - PA OVERRIDE		MONTHS WITHOUT PRIOR APPROVAL		occurrence has been reached.		made for same/similar procedure within set time frame.
5572	1 UNIT ALLOWED PER ROLLING MONTH -	5572	ONE UNIT ALLOWED PER ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		MONTH WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5573	3 UNITS ALLOWED PER CALENDAR YEAR -	5573	THREE UNITS ALLOWED PER CALENDAR	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		YEAR WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5574	2 UNITS ALLOWED PER 12 ROLLING	5574	TWO UNITS ALLOWED PER TWELVE	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS-PA OVERRIDE		ROLLING MONTHS WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5575	3 UNITS ALLOWED PER 2 ROLLING	5575	THREE UNITS ALLOWED PER TWO	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS -PA OVERRIDE		ROLLING MONTHS WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5576	1 UNIT ALLOWED PER ROLLING YEAR	5576	ONE UNIT ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
					occurrence has been reached.		exceeds our acceptable maximum.
5577	6 UNITS ALLOWED PER CALENDAR YEAR -	5577	SIX UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5578	2 UNITS ALLOWED PER 6 ROLLING	5578	TWO UNITS ALLOWED PER 6 ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS -PA OVERRIDE		MONTHS WITHOUT PRIOR APPROVAL		occurrence has been reached.		exceeds our acceptable maximum.
5579	1 UNIT ALLOWED PER 60 ROLLING	5579	ONE UNIT ALLOWED PER SIXTY ROLLING	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS		MONTHS		occurrence has been reached.		exceeds our acceptable maximum.
5580	1 UNIT ALLOWED PER 365 ROLLING DAYS	5580	ONE UNIT ALLOWED PER 365 ROLLING	119	Benefit maximum for this time period or	N640	Exceeds number/frequency
			DAYS		occurrence has been reached.		approved/allowed within time period.
5581	1 UNIT ALLOWED PER 730 DAYS	5581	ONE UNIT ALLOWED PER SEVEN	119	Benefit maximum for this time period or	N640	Exceeds number/frequency
			HUNDRED AND ELEVEN DAYS		occurrence has been reached.		approved/allowed within time period.
5582	2 UNITS ALLOWED PER 30 ROLLING DAYS	5582	TWO UNITS ALLOWED PER THIRTY	119	Benefit maximum for this time period or	N640	Exceeds number/frequency
			ROLLING DAYS		occurrence has been reached.		approved/allowed within time period.
5583	1 UNIT ALLOWED PER 36 ROLLING	5583	ONE UNIT ALLOWED PER THIRTY-SIX	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	MONTHS - PA OVERRIDE	1	ROLLING MONTHS WITHOUT PRIOR	1	occurrence has been reached.	1	exceeds our acceptable maximum.
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5584	1 UNIT ALLOWED PER 60 ROLLING MONTHS -PA OVERRIDE	5584	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5585	2 UNITS ALLOWED PER ROLLING YEAR - PA OVERRIDE	5585	TWO UNITS ALLOWED PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5586	60 UNITS ALLOWED PER 120 DAYS	5586	60 UNITS ALLOWED PER 60 ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5587	7 UNITS ALLOWED PER 3 ROLLING MONTHS	5587	SEVEN UNITS ALLOWED PER 3 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5588	1 UNIT ALLOWED PER 58 ROLLING MONTHS	5588	ONE UNIT ALLOWED PER FIFTY-EIGHT ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5589	4 UNITS ALLOWED PER ROLLING YEAR - PA OVERRIDE	5589	FOUR UNITS ALLOWED PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5590	120 UNITS ALLOWED PER 1 ROLLING MONTH -PA OVERRIDE	5590	ONE HUNDRED TWENTY UNITS ALLOWED PER 1 ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5591	5 UNITS ALLOWED PER DAY	5591	FIVE UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5592	1 UNIT ALLOWED PER 24 ROLLING MONTHS - PA OVERRIDE	5592	ONE UNIT ALLOWED PER TWENTY-FOUR ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5593	1 UNIT ALLOWED PER 60 ROLLING MONTHS - PA OVERRIDE	5593	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5594	1 UNIT ALLOWED PER 12 ROLLING MONTHS - PA OVERRIDE	5594	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5595	4 UNITS ALLOWED PER ROLLING YEAR - PA OVERRIDE	5595	FOUR UNITS ALLOWED PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5596	1 UNIT ALLOWED PER 36 ROLLING MONTHS - PA OVERRIDE	5596	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5597	1 UNIT ALLOWED PER ROLLING MONTH	5597	ONE UNIT ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5598	2 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5598	TWO UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5599	1 UNIT ALLOWED PER 3 ROLLING YEARS - PA OVERRIDE	5599	ONE UNIT ALLOWED PER 3 ROLLING YEARS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5600	2 UNITS ALLOWED PER 24 ROLLING MONTHS -PA OVERRIDE	5600	TWO UNITS ALLOWED PER TWENTY-FOUR ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5601	9 UNITS ALLOWED PER 11 ROLLING MONTHS	5601	NINE UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5602	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5602	ONE UNIT ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5603	4 UNITS ALLOWED PER DAY	5603	FOUR UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5605	2 UNITS ALLOWED PER 60 ROLLING MONTHS -PA OVERRIDE	5605	TWO UNITS ALLOWED PER SIXTY ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5606	100 UNITS ALLOWED PER 1 ROLLING MONTH -PA OVERRIDE	5606	ONE HUNDRED UNITS ALLOWED PER 1 ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5607	20 UNITS ALLOWED PER LIFETIME - PA OVERRIDE	5607	TWENTY UNITS ALLOWED PER LIFETIME WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5608	16 UNITS ALLOWED PER DAY - PA OVERRIDE	5608	16 UNITS ALLOWED PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5609	1 UNIT ALLOWED PER 7 ROLLING DAYS	5609	ONE UNIT ALLOWED PER 7 ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5610	2 UNITS ALLOWED PER LIFETIME	5610	TWO UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5611	24 UNITS ALLOWED PER DAY	5611	TWENTY-FOUR UNITS ALLOWED PER DAY	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5612	12 ENCOUNTERS ALW PER CALENDAR YEAR - PA OVERRIDE	5612	TWELVE ENCOUNTERS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5613	2 UNITS ALLOWED PER CALENDAR YEAR	5613	TWO UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5614	2 UNITS ALLOWED PER CALENDAR MONTH	5614	TWO UNITS ALLOWED PER 1 CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5615	2 UNITS ALLOWED PER 6 CALENDAR MONTHS	5615	TWO UNITS ALLOWED PER 6 CALENDAR MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5616	2 UNITS ALLOWED PER 11 ROLLING MONTHS-PA OVERRIDE	5616	TWO UNITS ALLOWED PER ELEVEN ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5617	1 UNIT ALLOWED PER 5 ROLLING YEARS	5617	ONE UNIT ALLOWED PER 5 ROLLING YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5618	2 UNITS ALLOWED PER 90 ROLLING DAYS- PA OVERRIDE	5618	TWO UNITS ALLOWED PER NINETY ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5619	24 ENCOUNTERS ALLWED PER CALENDAR YEAR-PA OVERRIDE	5619	TWENTY-FOUR ENCOUNTERS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5620	1 UNIT ALLOWED PER DAY	5620	ONE UNIT ALLOWED PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5621	1 UNIT ALLOWED PER 9 ROLLING MONTHS - PA OVERRIDE	5621	ONE UNIT ALLOWED PER NINE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5622	1 UNIT ALLOWED PER DAY	5622	ONE UNIT ALLOWED DAY PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5623	16 PER 365 DAYS, 8 PER NEXT 365 DAYS	5623	16 UTS 1ST ROL 365 DAYS 8 UTS EA SUB	119	Benefit maximum for this time period or	N362	The number of Days or Units of Service
	PA OVERRIDE		ROLL 365 DAYS PCODES WITH G W/O PA		occurrence has been reached.		exceeds our acceptable maximum.
5624	1 UNIT ALLOWED PER CALENDAR YEAR	5624	ONE UNIT ALLOWED PER CALENDAR YEAR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5626	16 UNITS ALLOWED PER DAY	5626	16 UNITS ALLOWED PER DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
5627	1 UNIT ALLOWED PER 11 ROLLING MONTHS - PA OVERRIDE	5627	ONE UNIT ALLOWED PER ELEVEN ROLLING MONTHS WITHOUT PRIOR APPROVAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5628	1 UNIT ALLOWED PER 181 ROLLING DAYS	5628	ONE UNIT ALLOWED PER ONE HUNDRED EIGHTY-ONE ROLLING DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5629	1 UNIT ALLOWED PER LIFETIME	5629	ONE UNIT ALLOWED PER LIFETIME	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5630	1 UNIT ALLOWED PER 90 ROLLING DAYS	5630	ONE UNIT ALLOWED PER NINETY ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5631	1 UNIT ALLOWED PER DAY	5631	ONE UNIT ALLOWED PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODI	E ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5632	1 UNIT ALLOWED PER 270 ROLLING DAYS - PA OVERRIDE	5632	ONE UNIT ALLOWED PER 270 ROLLING DAYS WITHOUT PRIOR APPROVAL	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N495	Missing Supplemental Medical Report.
5633	1 UNIT ALLOWED PER 175 ROLLING DAYS - PA OVERRIDE	- 5633	ONE UNIT ALLOWED PER ONE HUNDRED SEVENTY-FIVE ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5634	1 UNIT ALLOWED PER 24 ROLLING DAYS	5634	ONE UNIT ALLOWED PER TWENTY-FOUR ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5635	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5635	ONE UNIT ALLOWED PER SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5636	16 UNITS ALLOWED PER ROLLING MONTH	5636	SIXTEEN UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5637	20 UNITS ALLOWED PER ROLLING MONTH	5637	TWENTY UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5639	LIMIT OF FORTY HOURS PER WEEK.	5639	LIMIT OF FORTY HOURS PER WEEK.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5640	1 UNIT ALLOWED PER DAY	5640	ONE UNIT ALLOWED PER DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
5641	16 UNITS ALLOWED PER CALENDAR YEAR	5641	SIXTEEN UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5642	10 UNITS ALLOWED PER 10 ROLLING MONTHS	5642	TEN UNITS ALLOWED PER TEN ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5643	3 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	5643	THREE UNITS ALLOWED PER DELIVERY WITHOUT PRIOR APPROVAL	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre- certified/authorized services.
5644	4 UNITS ALLOWED PER C-SECTION DELIVERY-PA OVERRIDE	5644	FOUR UNITS ALLOWED PER C-SECTION DELIVERY WITHOUT PRIOR APPROVAL	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre- certified/authorized services.
5645	\$1300.00 ALLOWED PER ROLLING YEAR	5645	\$1300.00 ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5646	\$5200.00 ALLOWED PER ROLLING YEAR	5646	\$5200.00 ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5647	1 UNIT ALLOWED PER CALENDAR MONTH	5647	ONE UNIT ALLOWED PER CALENDAR MONTH	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
5648	\$2500 ALLOWED PER CALENDAR YEAR	5648	\$2500 ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5649	1 UNIT ALLOWED PER DAY	5649	ONE UNIT ALLOWED PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5650	24 UNITS ALLOWED PER CALENDAR YEAR	5650	TWENTY-FOUR UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5652	4 UNITS ALLOWED PER LIFETIME	5652	FOUR UNITS ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5653	2 UNITS ALLOWED PER 36 ROLLING MONTHS	5653	TWO UNITS ALLOWED PER THIRTY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5654	1 UNIT ALLOWED PER DAY	5654	ONE UNIT ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5655	2 UNITS ALLOWED PER 12 ROLLING MNTHS - PA OVERRIDE	5655	TWO UNITS ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5656	1 UNIT ALLOWED PER 36 ROLLING MONTHS	5656	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5657	1 UNIT ALLOWED PER 36 ROLLING MNTHS - PA OVERRIDE	5657	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5658	1 UNIT ALLOWED PER LIFETIME - PA OVERRIDE	5658	ONE UNIT ALLOWED PER LIFETIME WITHOUT PRIOR APPROVAL	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5659	1 UNIT ALLOWED PER 12 ROLLING MONTHS	5659	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5660	4 UNITS ALLOWED PER 60 ROLLING MNTHS - PA OVERRIDE	5660	FOUR UNITS ALLOWED PER 60 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5661	48 HOURS PER ENCOUNTER - PA OVERRIDE	5661	FORTY-EIGHT HOURS ALLOWED PER ENCOUNTER	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5662	RENTAL PRICE EXCEEDS PURCHASE PRICE	5662	RENTAL PRICE EXCEEDS PURCHASE PRICE	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5663	AMOUNT REDUCED BY HIST RENTAL PYMT	5663	AMOUNT REDUCED BY PREVIOUS RENTAL PAYMENT(S)	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
5664	1 UNIT PER 12 ROLLING MONTHS - PA OVERRIDE	5664	ONE UNIT PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5665	1 UNIT PER 60 ROLLING MONTHS - PA OVERRIDE	5665	ONE UNIT PER 60 ROLLING MONTHS WITHOUT PRIOR APPROVAL	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5666	40 UNITS ALLOWED PER CAL MONTH - PA OVERRIDE	5666	40 UNITS ALLOWED PER CAL MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5667	20 UNITS ALLOWED PER CAL MONTH - PA OVERRIDE	5667	20 UNITS ALLOWED PER CAL MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5668	8 UNITS ALLOWED PER CALENDAR YEAR	5668	8 UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5669	1 UNIT ALLOWED PER LIFETIME	5669	1 UNIT ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5670	500 UNITS ALLOWED PER CALENDAR MONTH PA OVERRIDE	5670	FIVE HUNDRED UNITS ALLOWED PER CALENDAR MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5671	1 UNIT PER 12 ROLLING MONTHS - PA OVERRIDE	5671	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5672	1 UNIT ALLOWED PER 90 ROLLING DAYS	5672	ONE UNIT ALLOWED PER NINETY ROLLING DAYS	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5673	1 UNIT ALLOWED PER 2 ROLLING MONTHS - PA OVERRIDE	5673	ONE UNIT ALLOWED PER 2 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5674	3 UNITS ALLOWED PER 2 ROLLING MONTHS - PA OVERRIDE	5674	THREE UNITS ALLOWED PER 2 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5675	5 UNITS ALLOWED PER 2 ROLLING MONTHS PA OVERRIDE	5675	FIVE UNITS ALLOWED PER 2 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5676	2 UNITS ALLOWED PER 6 ROLLING MONTHS -PA OVERRIDE	5676	TWO UNITS ALLOWED PER 6 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5677	2 UNITS ALLOWED PER 24 ROLLING MONTHS-PA OVERRIDE	5677	TWO UNITS ALLOWED PER 24 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5678	2 UNITS ALLWD PER 36 ROLLING MONTHS - PA OVERRIDE	5678	TWO UNITS ALLOWED PER 36 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5679	50 UNITS ALLOWED PER CALENDAR YEAR	5679	50 UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5680	2 UNITS ALLOWED PER LIFETIME	5680	TWO UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5681	1 UNIT PER 90 ROLLING DAYS - PA OVERRIDE	5681	ONE UNIT ALLOWED PER 90 ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5682	1 UNIT ALLOWED PER 6 ROLLING MONTHS - PA OVERRIDE	5682	ONE UNIT ALLOWED PER 6 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5683	50 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5683	50 UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5684	2 UNITS ALLOWED PER 60 ROLLING MONTHS	5684	TWO UNITS ALLOWED PER 60 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5685	2 UNITS ALLOWED PER 12 ROLLING MONTHS	5685	TWO UNITS ALLOWED PER 12 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5686	4 UNITS ALLOWED PER DAY - PA OVERRIDE	5686	4 UNITS ALLOWED PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5687	1 UNIT PER CALENDAR YEAR-PA OVERRIDE	5687	ONE UNIT PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5688	1 SER DATE W/IN 180 ROLL DAYS - PA OVERRIDE	5688	1 SERVICE DATE WITHIN 180 ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5689	4 UNITS ALLOWED PER CALENDAR WEEK	5689	4 UNITS ALLOWED PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5690	26 SESSIONS ALLOWED PER CALENDAR YEAR - PA OVERRID	5690	26 SESSIONS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5691	18 SESSIONS ALLOWED PER CALENDAR YEAR - PA OVERRID	5691	18 SESSIONS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5692	1 UNIT ALLOWED PER ROLLING YEAR - PA OVERRIDE	5692	ONE UNIT ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5693	4 UNITS ALLOWED PER CALENDAR MONTH	5693	4 UNITS ALLOWED PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5694	16 UNITS ALLOWED PER DAY - PA OVERRIDE	5694	16 UNITS PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5695	3 OCCURRENCES ALLWD WIN 90 ROLL DAYS - PA OVERRIDE	5695	3 OCCURRENCES WITHIN 90 ROLL DAYS W/OUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5696	2 UNITS ALLOWED PER CALENDAR MONTH - PA OVERRIDE	5696	2 UNITS PER CAL MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5697	20 UNITS PER 12 ROLLING MONTHS - PA OVERRIDE	5697	20 UNITS PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5698	3 UNITS PER 12 ROLLING MONTHS - PA OVERRIDE	5698	3 UNITS PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5699	1 UNIT ALLOWED PER DAY	5699	1 UNIT ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5700	5 UNITS ALLOWED PER CALENDAR WEEK	5700	5 UNITS ALLOWED PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5701	1 UNIT ALLOWED PER 6 ROLLING MONTHS - PA OVERRIDE	5505	ONE UNIT ALLOWED PER ROLLING SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5702	6 UNITS ALLOWED PER LIFETIME - PA OVERRIDE	6110	DENTAL SERVICES LIFETIME LIMIT HAS BEEN MET	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5703	1 UNIT ALLOWED PER 60 ROLLING MONTHS	5703	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5704	24 HOURS ALLOWED PER DAY	5704	Habilitation units exceeded 24 hours a day.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5705	3 DATES ALLOWED PER 90 DAYS	5705	Three dates allowed in 90 days	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5706	1 DATE ALLOWED PER 180 DAYS	5706	One date allowed in 180 days	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5707	2 UNITS ALLOWED PER CALENDAR MONTH	5707	Two units allowed in a calendar month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5708	1 UNIT ALLOWED PER 90 DAYS	5708	One unit allowed in 90 days	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5709	4 UNITS ALLOWED PER CALENDAR YEAR	5709	Four units allowed in a calendar year	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5710	6 UNITS ALLOWED PER 12 MONTHS	5710	Six units allowed in 12 months	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5711	26 UNITS ALLOWED PER CALENDAR YEAR	5711	26 units allowed in a calendar year	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5712	10 UNITS ALLOWED PER CALENDAR MONTH	5712	10 units allowed in a calendar month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5713	5 UNITS ALLOWED PER CALENDAR MONTH	5713	5 units allowed in a calendar month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5716	LIMIT OF 12 HOURS PER NPI PER DAY	5716	LIMIT OF 12 HOURS PER NPI PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5717	4 UNITS ALLOWED PER CALENDAR WEEK - PA OVERRIDE	5717	4 UNITS ALLOWED PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5718	16 UNITS ALLOWED PER DAY - PA OVERRIDE	5718	16 UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5719	160 UNITS ALLOWED PER CALENDAR MONTH - PA OVERRIDE	5719	160 UNITS ALLOWED PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5724	8 UNITS ALLOWED PER DAY - PA OVERRIDE	5724	8 UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5725	24 ENCOUNTERS PER ROLLING 12 MOS - PA OVERIDE	5725	24 ENCOUNTERS ALLOWED PER 12 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5726	\$3000 ALLOWED PER FISCAL YEAR (JULY 1 JUNE 30)	5726	\$3000 ALLOWED PER FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5727	7 VISITS ALLOWED PER ROLLING YEAR	5727	7 visits allowed per rolling year	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5728	3 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	5728	THREE UNITS ALLOWED PER DELIVERY WITHOUT PRIOR APPROVAL	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre- certified/authorized services.
5729	4 UNITS ALLOWED PER C-SECTION DELIVERY-PA OVERRIDE	5729	FOUR UNITS ALLOWED PER C-SECTION DELIVERY WITHOUT PRIOR APPROVAL	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre- certified/authorized services.
5730	ID WAIVER-1 UNIT PER 3 ROLLING MOS - PA OVERRIDE	5730	1 UNIT ALLOWED PER 3 ROLLING MONTHS - PA OVERRIDE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5731	200 UNITS ALLOWED PER ROLLING MONTH	5731	200 UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6000	MANUAL PRICING REQUIRED	617	Claim denied- please resubmit with correct units.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N430	Procedure code is inconsistent with the units billed.
6000	MANUAL PRICING REQUIRED	653	CLAIM REQUIRES MANUAL PRICING. PLEASE ATTACH INVOICE FOR MEDICAL SERVICES.	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N445	Missing document for actual cost or paid amount.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6100	INVALID COMB OF PROCEDURES SAME DAY	6100	INVALID COMBINATION OF PROCEDURES BILLED SAME CALENDAR DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
6101	INTRAORAL IMAGE NOT ALLOWED SAME DAY	6101	INTRAORAL IMAGE PROCEDURES NOT ALLOWED SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6102	ANESTHESIA NOT ALLOWED SAME DAY	6102	ANESTHESIA SEVICES NOT ALLOWED SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
6103	T1017 & G9012 CANNOT BE BILLED ON SAME DAY	6103	T1017 & G9012 CANNOT BE BILLED ON SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6104	EVALUATION PREVIOUSLY PAID FOR CALENDAR YEAR	6104	EVALUATION PREVIOUSLY PAID FOR CALENDAR YEAR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6105	EVALUATION PREVIOUSLY PAID WITHIN 90 DAYS	6105	EVALUATION PREVIOUSLY PAID WITHIN 90 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6106	INFUSION PUMP ALLOWED 1/366 DAYS	6106	INFUSION PUMP PREVIOUSLY PAID WITHIN 366 DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6107	INVALID COMBINATION OF PROCEDURE CODES	6107	INVALID COMBINATION OF PROCEDURE CODES BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6108	DENTAL SVCS NOT ALLOWED WITHIN 61 DAYS	6108	DENTAL SERVICES NOT ALLOWED WITHIN 61 DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6109	DENT SVCS NOT ALLWD WITHIN 180 DAYS AFTER SEALANT	6109	DENTAL SERVICES NOT ALLOWED WITHIN 180 DAYS AFTER SEALANT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6110	DENTAL SVCS ALLOWED PER LIFETIME	6110	DENTAL SERVICES LIFETIME LIMIT HAS BEEN MET	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6111	DENT SVCS NOT ALLWD UP TO 91 DAYS AFTER EXTRACTION	6111	DENTAL SERVICES NOT ALLOWED UP TO 91 DAYS BEFORE RELATED CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6112	ADULT DAY CARE PROCEDURES NOT ALLOWED SAME DAY	6112	ADULT DAY CARE PROCEDURES NOT ALLOWED SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6113	SEALANT ON SAME TOOTH ALLOWED ONCE PER LIFETIME	6113	SEALANT ON SAME TOOTH ALLOWED ONCE PER LIFETIME	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N117	This service is paid only once in a patients lifetime.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6114	C-SECTION OB VS VAG OB	6114	C-SECTION DELIVERY DATE CONFLICTS WITH VAGINAL DELIVERY DATE	96	Non-covered charge(s). At least one Remark Code must be provided (may be	N525	These services are not covered when performed within the global period of
					comprised of either the NCPDP Reject		another service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
6115	DENTURE PROCS NOT REIMBURSEABLE	6115	DENTAL PROCEDURES NOT ALLOWED UP	119	Benefit maximum for this time period or	N640	Exceeds number/frequency
	WITHIN 180 DAYS		TO 180 DAYS AFTER HISTORY CLAIM		occurrence has been reached.		approved/allowed within time period.
6116	CARE AFTER DEL-GLOBAL DEL NOT REIMB	6116	CARE AFTER DELIVERY - GLOBAL DELIVERY	97	The benefit for this service is included in	M86	Service denied because payment already
	WITHIN 90 DAYS		NOT ALLOWED WITHIN 90 DAYS		the payment/allowance for another		made for same/similar procedure within
					service/procedure that has already been		set time frame.
					adjudicated. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
6117	VAG OB VS C-SECTION OB	6117	VAGINAL DELIVERY CONFLICTS WITH C-	96	Non-covered charge(s). At least one	N525	These services are not covered when
			SECTION DELIVERY DATE		Remark Code must be provided (may be		performed within the global period of
					comprised of either the NCPDP Reject		another service.
					Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Usage:		
					Refer to the 835 Healthcare Policy		
					Identification Segment (loop 2110 Service		
					Payment Information REF), if present.		
6118	PANORAMIC XRAY CONFLICT	6118	PANORAMIC XRAY PROCEDURE CONFLICT	119	Benefit maximum for this time period or	N640	Exceeds number/frequency
					occurrence has been reached.		approved/allowed within time period.
6120	DNY PROC WITH RB/MS IF RR CDE PD	6120	MODIFIERS RB/MS CONFLICTS WITH	97	The benefit for this service is included in	M86	Service denied because payment already
	W/IN SAME CAL MTH		PREVIOUSLY PAID RR MODIFIER WITHIN		the payment/allowance for another		made for same/similar procedure within
			SAME CALENDAR MONTH		service/procedure that has already been		set time frame.
					adjudicated. Usage: Refer to the 835		
					Healthcare Policy Identification Segment		
					(loop 2110 Service Payment Information		
					REF), if present.		
6121	RECEMENT/REBOND CROWN NOT ALWD	6121	RECEMENT/REBOND CROWN NOT	273	Coverage/program guidelines were	N362	The number of Days or Units of Service
	WITHIN 12 MONTHS		ALLOWED UP TO 12 MONTHS AFTER		exceeded.		exceeds our acceptable maximum.
			PREVIOUSLY PAID DENTAL PROCEDURE				
6122	PROCEDURE NON-COVERED SAME ICN	6122	PROCEDURE(S) NON-COVERED ON THE	16	Claim/service lacks information or has	M51	Missing/incomplete/invalid procedure
			SAME CLAIM		submission/billing error(s). Usage: Do not		code(s).
					use this code for claims		1
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
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ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6123	ADULT/NEONATAL DAYS NOT ALLOWED ON SAME ICN	6123	ADULT/NEONATAL DAYS NOT ALLOWED ON THE SAME CLAIM	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N15	Services for a newborn must be billed separately.
6124	PSYCHIATRIC OFFICE VISITS NOT ALLOWED SAME DAY	6124	PSYCHIATRIC OFFICE VISITS NOT ALLOWED SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6125	MULTIPLE PROCEDURE RULE NOT FOLLOWED	6125	MULTIPLE SURGICAL PROCEDURES ON SAME DATE OF SERVICE	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
6127	BILATERAL PROCEDURE RULE NOT FOLLOWED	6127	BILATERAL PROCEDURE RULE NOT FOLLOWED	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
6128	PRESUMPTIVE G CODE SAME DAY	6128	PRESUMPTIVE PROCEDURES NOT ALLOWED SAME DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
6130	T1016 U1 NOT ALLWD W T1016 U1 W/IN 11 RLG CAL MO	6130	T1016 U1 NOT ALLWD W T1016 U1 W/IN 11 RLG CAL MO	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6131	ASST SURG MOD AND CO-SURG MOD NOT ALWD ON SAME DOS	6131	ASSISTANT SURGEON MODIFIER AND CO- SURGEON MODIFIER NOT ALLOWED ON THE SAME DATE OF SERVICE	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
6133	PROCEDURE D7261/D7241 CONFLICT	6133	PROCEDURE D7261/D7241 CONFLICT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6134	UNBUNDLING OF TECH/PROF MODS	6134	UNBUNDLING OF TECH/PROF MODS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6136	DENTAL SVCS NOT ALLOWED ON SAME DATE OF SERVICE	6136	DENTAL SERVICES NOT ALLOWED ON SAME DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6138	CCBHC/CLINIC SVCS NOT ALLOWED SAME DAY	6138	CCBHC/CLINIC SERVICES NOT ALLOWED SAME DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6139	T1016 NO MOD NOT ALWD W T1016 U1- U4 SAME CAL MO	6139	T1016 NO MOD NOT ALWD W T1016 U1- U4 SAME CAL MO	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6140	SAME PROCEDURE SAME DAY DIFFERENT MODIFIERS	6140	SAME PROCEDURE, SAME DAY, DIFFERENT MODIFIERS	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6141	LAB TESTS CANNOT BE BILLED SAME DAY	6141	LAB TESTS CANNOT BE BILLED ON SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6142	INVALID HOSPICE REV/COMB SAME DAY CLAIM DETAIL	6142	INVALID HOSPICE REV/COMB SAME DAY CLAIM DETAIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.
6143	NOT ALLOWED WITHIN 60 DAYS FROM EXTRACTION DATE	6143	NOT ALLOWED WITHIN 60 DAYS FROM EXTRACTION DATE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6144	MODIFIER U8 ALLOWED ONCE PER 12 ROLLING MONTHS	6144	MODIFIER U8 IS PAYABLE ONCE PER ROLLING YEAR FOR SPECIALIZED FOSTER CARE SERVICES, PROVIDER TYPE 86	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6145	TELEHEALTH CALL NOT ALLOWED AFTER E&M SERVICE	6145	TELEHEALTH CALL NOT ALLOWED AFTER E&M SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6146	E&M SERVICE NOT ALLOWED AFTER TELEHEALTH CALL	6146	E&M SERVICE NOT ALLOWED AFTER TELEHEALTH CALL	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6147	TELEHEALTH CALL NOT ALLOWED BEFORE E&M SERVICE	6147	TELEHEALTH CALL NOT ALLOWED BEFORE E&M SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6148	ID WAIVER-DENT SVCS NOT ALLWD UP TO 91 DAYS AFTER	6148	DENT SVCS NOT ALLWD UP TO 91 DAYS AFTER RELATED CLAIM	97	the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6500	REQUIRED TO BILL WITH OTHER PROCEDURE	6500	PROCEDURE NOT REIMBURSEABLE WITHOUT PRIMARY CODE	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.
6501	EPIDURAL CLM REVIEW NO PRIMARY PROC WITHIN 10 DAYS	6501	EPIDURAL CLM REVIEW NO PRIMARY PROC WITHIN 10 DAYS	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.
6502	PROSTHETIC NOT BILLED IN LAST 365 DAYS	6502	PROCEDURE NOT REIMBURSEABLE WITHOUT PREVIOUSLY PAID PROSTHETIC PROCEDURE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.
6503	CATARACT SURGERY NOT PAID BY MCARE	6503	CATARACT SURGERY HAS NOT BEEN PAID	22	This care may be covered by another	N598	Health care policy coverage is primary.
	PART B		BY MEDICARE PART B		payer per coordination of benefits.		
6504	T1016 MOD U1 NOT PAID DURING PREVIOUS CALENDAR MO	6504	T1016 MOD U1 NOT PAID DURING PREVIOUS CALENDAR MO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N674	Not covered unless a pre-requisite procedure/service has been provided.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6505	T1016 MOD U2 NOT PAID DURING PREVIOUS CALENDAR MO	6505	T1016 MOD U2 NOT PAID DURING PREVIOUS CALENDAR MO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6506	T1016 MOD U3 NOT PAID DURING PREVIOUS CALENDAR MO	6506	T1016 MOD U3 NOT PAID DURING PREVIOUS CALENDAR MO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N674	Not covered unless a pre-requisite procedure/service has been provided.
6507	PHARM CLM FOR NEW PRESCRIP NOT PD IN LAST 30 DAYS	6507	RECIPIENT HAS NO NEW PRESCRIPTION IN THE LAST 30 DAYS	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6508	PAID DENTAL EXAM CODE NOT ON FILE	6508	PAID DENTAL EXAM CODE NOT ON FILE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6509	PROVIDER TYPE 86 ELIGIBILITY CHECKLIST NOT RECEIVE	6509	PROVIDER TYPE 86 ELIGIBILITY CHECKLIST NOT RECEIVED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6510	ADD-ON CODE BILLED W/O PAID PRIMARY	6510	ADD-ON CODE BILLED W/O PAID PRIMARY	B15	This service/procedure requires that a	N122	Add-on code cannot be billed by itself.
	WITHIN 2 DAYS		WITHIN 2 DAYS		qualifying service/procedure be received		
					and covered. The qualifying other		
					service/procedure has not been		
					received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
					illioithation KEF), ii present.		
6511	ADD-ON CODE BILLED W/O PAID PRIMARY	6511	ADD-ON CODE BILLED W/O PAID PRIMARY	B15	This service/procedure requires that a	N122	Add-on code cannot be billed by itself.
İ					qualifying service/procedure be received		
					and covered. The qualifying other		
					service/procedure has not been		
					received/adjudicated. Usage: Refer to the		
					835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
6513	ID WAIVER-PROCEDURE NOT IN	6513	PROCEDURE NOT IN CONJUNCTION WITH	16	Claim/service lacks information or has	N301	Missing/incomplete/invalid procedure
	CONJUNCTION WITH BIOPSY		BIOPSY		submission/billing error(s). Usage: Do not		date(s).
					use this code for claims		
					attachment(s)/other documentation. At		
					least one Remark Code must be provided		
					(may be comprised of either the NCPDP		
					Reject Reason Code, or Remittance Advice		
					Remark Code that is not an ALERT.) Refer		
					to the 835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
6515	ADD-ON CODE BILLED W/O PAID PRIMARY	6511	ADD-ON CODE BILLED W/O PAID PRIMARY	B15	This service/procedure requires that a	N122	Add-on code cannot be billed by itself.
	LENS		·		qualifying service/procedure be received		· ·
					and covered. The qualifying other		
					service/procedure has not been		
					received/adjudicated. Usage: Refer to the		
					835 Healthcare Policy Identification		
					Segment (loop 2110 Service Payment		
					Information REF), if present.		
7200	MISCELLANEOUS CLAIMS XTEN ERROR	7200	This claim/service is pending for Xten	133	The disposition of this service line is		
7200	INISCELLANEOUS CEANNIS ATEN ERROR	7200	program review. No action is needed on	133	pending further review. (Use only with		
			your part.		Group Code OA). Usage: Use of this code		
			your part.		requires a reversal and correction when		
					the service line is finalized (use only in		
					Loop 2110 CAS segment of the 835 or		
					Loop 2430 of the 837).		
7000		7004		204			
7200	MISCELLANEOUS CLAIMS XTEN ERROR	7201	,	204	This service/equipment/drug is not		
			policies.		covered under the patients current benefit plan		
7201	DENIED - CLAIMS XTEN RESPONSE FAILED	7201	Denied by ClaimXten based on program	204	This service/equipment/drug is not		
			policies.		covered under the patients current		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
7211	PROCEDURE IS INVALID FOR PATIENT'S AGE	7211	Procedure Is Invalid For Patient's Age	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
7212	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (AGE)	7212	Procedure added due to Alt Code Replacement (Age).	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
7213	PROCEDURE IS INVALID FOR PATIENT'S SEX	7213	Procedure Is Invalid For Patient's Sex	7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
7214	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (SEX)	7214	Procedure Added Due to Alt Code Replacement (Sex).	7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
7215	PROCEDURE CODE IS INCIDENTAL	7215	Procedure Code Is Incidental	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N19	Procedure code incidental to primary procedure.
7216	NO SEPARATE REIMBURSEMENT FOR VISIT PROCEDURE	7216	No Separate Reimbursement for Visit Procedure.	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	N525	These services are not covered when performed within the global period of another service.
7217	PROCEDURE CODE HAS BEEN REBUNDLED	7217	Procedure Code Has Been Rebundled	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
7218	PROCEDURE ADDED DUE TO REBUNDLING	7218	Procedure Added Due to Rebundling.	234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
7219	PROCEDURE IS MUTUALLY EXCLUSIVE	7219	Procedure Is Mutually Exclusive	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.
7220	PROCEDURE IS WITHIN THE NUM OF DAYS PRE-OP RANGE	7220	Procedure is Within the Number of Days Pre-Op Range.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.
7221	PROCEDURE IS WITHIN THE NUM OF DAYS POST-OP RA	7221	Procedure is Within the Number of Days Post-Op Range.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N351	Service date outside of the approved treatment plan service dates.
7222	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON	7222	Procedure Does Not Require an Assistant Surgeon.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
7233	DENIED DUPLICATE- INCLUDES UNILATERAL OR BILATERAL	7233	Denied Duplicate - Includes Unilateral or Bilateral	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
7235	PROCEDURE EXCEEDS MAX NUMBER ALLOWED PER LIFETIME	7235	PROCEDURE EXCEEDS MAX NUMBER ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
7236	DUPLICATE PROCEDURE ONLY ALLOWED ONCE PER DAY	7236	DUPLICATE PROCEDURE ONLY ALLOWED ONCE PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
7238	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING	7238	Procedure Added Due to Duplicate Rebundling.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
7242	DX TO PX COMPARISON PROCEDURE DENIED	7242	Claim Line Flagged for Unexpected Diagnosis with Procedure Billed.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
7244	MEDICAL VISIT DENIED (CLAIMREVIEW)	7244	ESTABLISHED PATIENT - NEW VISIT PX NOT ALLOWED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
7245	PX ADDED DUE TO NEW VISIT FREQ CODE REPLACEMENT	7245	Px Added Due to New Visit Freq Code Replacement.	B16	New Patient qualifications were not met.	N113	Only one initial visit is covered per physician, group practice or provider.
7261	INVALID PROCEDURE CODE	7261	Invalid Procedure Code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
7269	MODIFIER NOT VALID FOR THE DATE OF SERVICE	7269	Modifier Not Valid for the Date of Service.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION	7270	Invalid Modifier/Procedure Code Combination.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
7281	PROCEDURE NOT INDICATED FOR DIAGNOSIS	7281	Procedure Code Not Indicated for Diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have w
7292	PROCEDURE EXCEEDS MAXIMUM NUMBER ALLOWED PER DAY	7292	Procedure Exceeds Maximum Number Allowed Per Day.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
7293	ADDITIONAL UNITS MUST BE BILLED WITH ADD-ON CODES	7293	Additional Units Must Be Billed with Add- On Codes.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
7294	PROCEDURE INCLUDED IN GLOBAL PROCEDURE	7294	Procedure Included in Global Procedure.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.
7295	PX IS A COMPONENT OR CONFLICTING PROCEDURE	7295	PX is a Component or Conflicting Procedure.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
7500	BILLING PROVIDER ON PREPAYMENT REVIEW	3090	Billing provider under review - suspend all claims	243	Services not authorized by network/primary care providers.	N95	This provider type/provider specialty may not bill this service.
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW	3051	Rendering provider under review - suspend all claims.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		