Code	Description
1	DEDUCTIBLE AMOUNT
2	COINSURANCE AMOUNT
3	Co-payment Amount
4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
5	THE PROCEDURE CODE/BILL TYPE IS INCONSISTENT WITH THE PLACE OF SERVICE.
6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENTS AGE.
7	The procedure/revenue code is inconsistent with the patients gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patients age.
10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENTS GENDER.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
17	Requested information was not provided or was insufficient/incomplete.
18	DUPLICATE CLAIM/SERVICE.
19	This is a work-related injury/illness and thus the liability of the Workers Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
24	Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	EXPENSES INCURRED PRIOR TO COVERAGE.
27	EXPENSES INCURRED AFTER COVERAGE TERMINATED.
28	Coverage not in effect at the time the service was provided.
29	THE TIME LIMIT FOR FILING HAS EXPIRED.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED.
33	INSURED HAS NO DEPENDENT COVERAGE.
34	Insured has no coverage for newborns.
35	LIFETIME BENEFIT MAXIMUM HAS BEEN REACHED.
36	Balance does not exceed co-payment amount.
37	Balance does not exceed deductible.
38	SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK/PRIMARY CARE) PROVIDERS.
39	SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED.
40	CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENT/URGENT CARE.
41	DISCOUNT AGREED TO IN PREFERRED PROVIDER CONTRACT.
42	CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
43	GRAMM-RUDMAN REDUCTION.
44	PROMPT-PAY DISCOUNT.
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) not covered.
49	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS A ROUTINE EXAM OR SCREENING PROCEDURE DONE IN CONJUNCTION WITH A ROUTINE EXAM.
50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A MEDICAL NECESSITY BY THE PAYER.
51	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS A PRE-EXISTING CONDITION.
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

Code	Description
53	Services by an immediate relative or a member of the same household are not covered.
54	MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS CASE.
55	Procedure/treatment is deemed experimental/investigational by the payer.
56	Procedure/treatment has not been deemed proven to be effective by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this days supply.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
61	Penalty for failure to obtain second surgical opinion.
62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION.
63	Correction to a prior claim.
64	Denial reversed per Medical Review.
65	Procedure code was incorrect. This payment reflects the correct code.
66	Blood Deductible.
67	Lifetime reserve days.
68	DRG weight.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day.
73	Administrative days.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days.
78	Non-Covered days/Room charge adjustment.
79	Cost Report days.
80	Outlier days.
81	Discharges.
82	PIP days.
83	Total visits.
84	Capital Adjustment.
85	Patient Interest Adjustment.
86	Statutory Adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
93	No Claim level Adjustments.
94	Processed in Excess of charges.
95	Plan procedures not followed.
96	NON-COVERED CHARGE(S).
97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
99	Medicare Secondary Payer Adjustment Amount.
100	PAYMENT MADE TO PATIENT/INSURED/RESPONSIBLE PARTY/EMPLOYER.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount.
104	Managed care withholding.

Code	Description
105	Tax withholding.
106	Patient payment option/election not in effect.
107	The related or qualifying claim/service was not identified on this claim.
108	Rent/purchase guidelines were not met.
109	CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR.
110	BILLING DATE PREDATES SERVICE DATE.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
117	Transportation is only covered to the closest facility that can provide the necessary care.
118	ESRD network support adjustment.
119	Benefit maximum for this time period or occurrence has been reached.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
125	Submission/billing error(s).
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
128	Newborn services are covered in the mothers Allowance.
129	PRIOR PROCESSING INFORMATION APPEARS INCORRECT.
130	Claim submission fee.
131	CLAIM SPECIFIC NEGOTIATED DISCOUNT.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Interim bills cannot be processed.
136	Failure to follow prior payers coverage rules.
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	PATIENT/INSURED HEALTH IDENTIFICATION NUMBER AND NAME DO NOT MATCH.
141	Claim spans eligible and ineligible periods of coverage.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
145	Premium payment withholding
146	Diagnosis was invalid for the date(s) of service reported.
147	PROVIDER CONTRACTED/NEGOTIATED RATE EXPIRED OR NOT ON FILE.
148	INFORMATION FROM ANOTHER PROVIDER WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE.
149	LIFETIME BENEFIT MAXIMUM HAS BEEN REACHED FOR THIS SERVICE/BENEFIT CATEGORY.
150	PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
151	PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY/FREQUENCY OF SERVICES.
152	Payer deems the information submitted does not support this length of service.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this days supply.
155	Patient refused the service/procedure.
156	Flexible spending account payments.

Code	Description
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.
163	ATTACHMENT REFERENCED ON THE CLAIM WAS NOT RECEIVED.
164	ATTACHMENT REFERENCED ON THE CLAIM WAS NOT RECEIVED IN A TIMELY FASHION.
165	REFERRAL ABSENT OR EXCEEDED.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED.
168	SERVICE(S) HAVE BEEN CONSIDERED UNDER THE PATIENTS MEDICAL PLAN. BENEFITS ARE NOT AVAILABLE UNDER THIS DENTAL PLAN.
169	Alternate benefit has been provided.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Service was not prescribed by a physician.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is not current.
177	PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY REQUIREMENTS.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements.
180	Patient has not met the required residency requirements.
181	PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE.
182	PROCEDURE MODIFIER WAS INVALID ON THE DATE OF SERVICE.
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
186	Level of care change adjustment.
187	Consumer Spending Account payments.
188	This product/procedure is only covered when used according to FDA recommendations.
189	NOT OTHERWISE CLASSIFIED OR UNLISTED PROCEDURE CODE (CPT/HCPCS) WAS BILLED WHEN THERE IS A SPECIFIC PROCEDURE CODE FOR THIS PROCEDURE/SERVICE
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
191	Not a work related injury/illness and thus not the liability of the workers compensation carrier.
192	Non standard adjustment code from paper remittance.
193	ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	REFUND ISSUED TO AN ERRONEOUS PRIORITY PAYER FOR THIS CLAIM/SERVICE.
196	CLAIM/SERVICE DENIED BASED ON PRIOR PAYERS COVERAGE DETERMINATION.
197	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
198	PRECERTIFICATION/AUTHORIZATION EXCEEDED.
199	REVENUE CODE AND PROCEDURE CODE DO NOT MATCH.
200	EXPENSES INCURRED DURING LAPSE IN COVERAGE
201	Workers Compensation case settled.
202	NON-COVERED PERSONAL COMFORT OR CONVENIENCE SERVICES.
203	Discontinued or reduced service.
204	THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENTS CURRENT BENEFIT PLAN.
205	Pharmacy discount card processing fee
206	National Provider Identifier - missing.
207	National Provider identifier - Invalid format
208	National Provider Identifier - Not matched.

Code	Description
209	Per regulatory or other agreement.
210	PAYMENT ADJUSTED BECAUSE PRE-CERTIFICATION/AUTHORIZATION NOT RECEIVED IN A TIMELY FASHION.
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.
214	Workers Compensation claim adjudicated as non-compensable.
215	Based on subrogation of a third party settlement.
216	Based on the findings of a review organization.
217	Based on payer reasonable and customary fees.
218	Based on entitlement to benefits.
219	Based on extent of injury.
220	The applicable fee schedule does not contain the billed code.
221	Workers Compensation claim is under investigation.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
224	Patient identification compromised by identity theft.
225	Penalty or Interest Payment by Payer.
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete.
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X.
230	No available or correlating CPT/HCPCS code to describe this service.
231	MUTUALLY EXCLUSIVE PROCEDURES CANNOT BE DONE IN THE SAME DAY/SETTING.
232	Institutional Transfer Amount.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	THIS PROCEDURE IS NOT PAID SEPARATELY.
235	Sales Tax
236	THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE.
237	LEGISLATED/REGULATORY PENALTY.
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
241	Low Income Subsidy (LIS) Co-payment Amount
242	Services not provided by network/primary care providers.
243	Services not authorized by network/primary care providers.
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.
245	Provider performance program withhold.
246	This non-payable code is for required reporting only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
249	This claim has been identified as a readmission. (Use only with Group Code CO)
250	The attachment/other documentation content received is inconsistent with the expected content.
251	The attachment/other documentation content received did not contain the content required to process this claim or service.
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).
253	Sequestration - reduction in federal payment

Code	Description
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)
256	Service not payable per managed care contract.
257	The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
259	ADDITIONAL PAYMENT FOR DENTAL/VISION SERVICE UTILIZATION.
260	PROCESSED UNDER MEDICAID ACA ENHANCED FEE SCHEDULE
261	THE PROCEDURE OR SERVICE IS INCONSISTENT WITH THE PATIENT'S HISTORY.
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.)
268	THE CLAIM SPANS TWO CALENDAR YEARS. PLEASE RESUBMIT ONE CLAIM PER CALENDAR YEAR.
269	ANESTHESIA NOT COVERED FOR THIS SERVICE/PROCEDURE.
270	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN. SUBMIT THESE SERVICES TO THE PATIENT'S DENTAL PLAN FOR FURTHER CONSIDERATION.
271	PRIOR CONTRACTUAL REDUCTIONS RELATED TO A CURRENT PERIODIC PAYMENT AS PART OF A CONTRACTUAL PAYMENT SCHEDULE WHEN DEFERRED AMOUNTS HAVE BEEN PREVIOUSLY REPORTED.
272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET.
273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED.
274	FEE/SERVICE NOT PAYABLE PER PATIENT CARE COORDINATION ARRANGEMENT.
275	PRIOR PAYER'S (OR PAYERS') PATIENT RESPONSIBILITY (DEDUCTIBLE, COINSURANCE, CO-PAYMENT) NOT COVERED.
276	SERVICES DENIED BY THE PRIOR PAYER(S) ARE NOT COVERED BY THIS PAYER.
277	THE DISPOSITION OF THE CLAIM/SERVICE IS UNDETERMINED DURING THE PREMIUM PAYMENT GRACE PERIOD, PER HEALTH INSURANCE SHOP EXCHANGE REQUIREMENTS. THIS CLAIM/SERVICE WILL BE REVERSED AND CORRECTED WHEN THE GRACE PERIOD ENDS (DUE TO PREMIUM PAYMENT OR LACK OF PREMIUM PAYMENT).
278	PERFORMANCE PROGRAM PROFICIENCY REQUIREMENTS NOT MET.
279	SERVICES NOT PROVIDED BY PREFERRED NETWORK PROVIDERS.
280	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN. SUBMIT THESE SERVICES TO THE PATIENT'S PHARMACY PLAN FOR FURTHER CONSIDERATION.
281	DEDUCTIBLE WAIVED PER CONTRACTUAL AGREEMENT.
282	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE TYPE OF BILL
283	ATTENDING PROVIDER IS NOT ELIGIBLE TO PROVIDE DIRECTION OF CARE.
284	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES.
285	APPEAL PROCEDURES NOT FOLLOWED
286	APPEAL TIME LIMITS NOT MET
287	REFERRAL EXCEEDED
288	REFERRAL ABSENT
289	SERVICES CONSIDERED UNDER THE DENTAL AND MEDICAL PLANS, BENEFITS NOT AVAILABLE.
290	CLAIM RECEIVED BY THE DENTAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN. CLAIM HAS BEEN FORWARDED TO THE PATIENT'S MEDICAL PLAN FOR FURTHER CONSIDERATION.
291	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN. CLAIM HAS BEEN FORWARDED TO THE PATIENT'S DENTAL PLAN FOR FURTHER CONSIDERATION.
292	CLAIM RECEIVED BY THE MEDICAL PLAN, BUT BENEFITS NOT AVAILABLE UNDER THIS PLAN. CLAIM HAS BEEN FORWARDED TO THE PATIENT'S PHARMACY PLAN FOR FURTHER CONSIDERATION.
293	PAYMENT MADE TO EMPLOYER.
294	PAYMENT MADE TO ATTORNEY.
#C	SYSTEM-CAPITATED SERVICE
A0	Patient refund amount.

Code	Description
A1	Claim/Service denied.
A2	Contractual adjustment.
A3	Medicare Secondary Payer liability met.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Ungroupable DRG.
B1	Non-covered visits.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid.
B11	THE CLAIM/SERVICE HAS BEEN TRANSFERRED TO THE PROPER PAYER/PROCESSOR FOR PROCESSING.
B12	Services not documented in patients medical records.
B13	PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
B14	Only one visit or consultation per physician per day is covered.
B15	This service/procedure requires that a qualifying service/procedure be received and covered.
B16	New Patient qualifications were not met.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	This procedure code and modifier were invalid on the date of service.
B19	Claim/service adjusted because of the finding of a Review Organization.
B2	Covered visits.
B20	Procedure/service was partially or fully furnished by another provider.
B21	THE CHARGES WERE REDUCED BECAUSE THE SERVICE/CARE WAS PARTIALLY FURNISHED BY ANOTHER PHYSICIAN.
B22	This payment is adjusted based on the diagnosis.
B23	PROCEDURE BILLED IS NOT AUTHORIZED PER YOUR CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) PROFICIENCY TEST.
B3	Covered charges.
B4	Late filing penalty.
B5	Coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Alternative services were available, and should have been utilized.
B9	Patient is enrolled in a Hospice.
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M102	Service not performed on equipment approved by the FDA for this purpose.
M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.

Code	Description
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.
M117	Not covered unless submitted via electronic claim.
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M121	We pay for this service only when performed with a covered cryosurgical ablation.
M122	Missing/incomplete/invalid level of subluxation.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
M124	Missing indication of whether the patient owns the equipment that requires the part or supply.
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
M126	Missing/incomplete/invalid individual lab codes included in the test.
M127	Missing patient medical record for this service.
M129	Missing/incomplete/invalid indicator of x-ray availability for review.
M13	Only one initial visit is covered per specialty per medical group.
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131	Missing physician financial relationship form.
M132	Missing pacemaker registration form.
M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
M134	Performed by a facility/supplier in which the provider has a financial interest.
M135	Missing/incomplete/invalid plan of treatment.
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
M137	Part B coinsurance under a demonstration project or pilot program.
M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
M139	Denied services exceed the coverage limit for the demonstration.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M141	Missing physician certified plan of care.
M142	Missing American Diabetes Association Certificate of Recognition.
M143	The provider must update license information with the payer.
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
M19	Missing oxygen certification/re-certification.
M2	Not paid separately when the patient is an inpatient.
M20	Missing/incomplete/invalid HCPCS.
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.
M22	Missing/incomplete/invalid number of miles traveled.
M23	Missing invoice.
M24	Missing/incomplete/invalid number of doses per vial.

Code	Description
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.
M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Missing operative note/report.
M3	Equipment is the same or similar to equipment already being used.
M30	Missing pathology report.
M31	Missing radiology report.
M32	Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
M37	Not covered when the patient is under age 35.
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
M4	Alert: This is the last monthly installment payment for this durable medical equipment.
M40	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.
M44	Missing/incomplete/invalid condition code.
M45	Missing/incomplete/invalid occurrence code(s).
M46	Missing/incomplete/invalid occurrence span code(s).
M47	Missing/incomplete/invalid internal or document control number.
M49	Missing/incomplete/invalid value code(s) or amount(s).
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M50	Missing/incomplete/invalid revenue code(s).
M51	Missing/incomplete/invalid procedure code(s).
M52	Missing/incomplete/invalid “from” date(s) of service.
M53	Missing/incomplete/invalid days or units of service.
M54	Missing/incomplete/invalid total charges.
M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
M56	Missing/incomplete/invalid payer identifier.
M59	Missing/incomplete/invalid “to” date(s) of service.
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
M60	Missing Certificate of Medical Necessity.
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62	Missing/incomplete/invalid treatment authorization code.

Code	Description
M64	Missing/incomplete/invalid other diagnosis.
M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67	Missing/incomplete/invalid other procedure code(s).
M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
M71	Total payment reduced due to overlap of tests billed.
M73	The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.
M75	Multiple automated multichannel tests performed on the same day combined for payment.
M76	Missing/incomplete/invalid diagnosis or condition.
M77	Missing/incomplete/invalid place of service.
M79	Missing/incomplete/invalid charge.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	You are required to code to the highest level of specificity.
M82	Service is not covered when patient is under age 50.
M83	Service is not covered unless the patient is classified as at high risk.
M84	Medical code sets used must be the codes in effect at the time of service
M85	Subjected to review of physician evaluation and management services.
M86	Service denied because payment already made for same/similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.
M89	Not covered more than once under age 40.
M9	Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M90	Not covered more than once in a 12 month period.
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95	Services subjected to Home Health Initiative medical review/cost report audit.
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA02	Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
MA07	Alert: The claim information has also been forwarded to Medicaid for review.
MA08	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
MA09	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

Code	Description
MA10	Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
MA100	Missing/incomplete/invalid date of current illness or symptoms
MA103	Hemophilia Add On.
MA106	PIP (Periodic Interim Payment) claim.
MA109	Claim processed in accordance with ambulatory surgical guidelines.
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
MA112	Missing/incomplete/invalid group practice information.
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
MA114	Missing/incomplete/invalid information on where the services were furnished.
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution.
MA117	This claim has been assessed a $1.00 user fee.
MA118	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
MA120	Missing/incomplete/invalid CLIA certification number.
MA121	Missing/incomplete/invalid x-ray date.
MA122	Missing/incomplete/invalid initial treatment date.
MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA125	Per legislation governing this program, payment constitutes payment in full.
MA126	Pancreas transplant not covered unless kidney transplant performed.
MA128	Missing/incomplete/invalid FDA approval number.
MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
MA132	Adjustment to the pre-demonstration rate.
MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.
MA22	Payment of less than $1.00 suppressed.

Code	Description
MA23	Demand bill approved as result of medical review.
MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
MA26	Alert: Our records indicate that you were previously informed of this rule.
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.
MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA30	Missing/incomplete/invalid type of bill.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32	Missing/incomplete/invalid number of covered days during the billing period.
MA33	Missing/incomplete/invalid noncovered days during the billing period.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
MA35	Missing/incomplete/invalid number of lifetime reserve days.
MA36	Missing/incomplete/invalid patient name.
MA37	Missing/incomplete/invalid patient's address.
MA39	Missing/incomplete/invalid gender.
MA40	Missing/incomplete/invalid admission date.
MA41	Missing/incomplete/invalid admission type.
MA42	Missing/incomplete/invalid admission source.
MA43	Missing/incomplete/invalid patient status.
MA44	Alert: No appeal rights. Adjudicative decision based on law.
MA45	Alert: As previously advised, a portion or all of your payment is being held in a special account.
MA46	The new information was considered but additional payment will not be issued.
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.
MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA54	Physician certification or election consent for hospice care not received timely.
MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58	Missing/incomplete/invalid release of information indicator.
MA59	Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60	Missing/incomplete/invalid patient relationship to insured.
MA61	Missing/incomplete/invalid social security number or health insurance claim number.
MA62	Alert: This is a telephone review decision.
MA63	Missing/incomplete/invalid principal diagnosis.
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65	Missing/incomplete/invalid admitting diagnosis.
MA66	Missing/incomplete/invalid principal procedure code.
MA67	Correction to a prior claim.
MA68	Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
MA69	Missing/incomplete/invalid remarks.
MA70	Missing/incomplete/invalid provider representative signature.
MA71	Missing/incomplete/invalid provider representative signature date.

Code	Description
MA72	Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75	Missing/incomplete/invalid patient or authorized representative signature.
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA77	Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
MA79	Billed in excess of interim rate.
MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81	Missing/incomplete/invalid provider/supplier signature.
MA83	Did not indicate whether we are the primary or secondary payer.
MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
MA90	Missing/incomplete/invalid employment status code for the primary insured.
MA91	This determination is the result of the appeal you filed.
MA92	Missing plan information for other insurance.
MA93	Non-PIP (Periodic Interim Payment) claim.
MA94	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.
MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.
MA99	Missing/incomplete/invalid Medigap information.
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
N100	PPS (Prospect Payment System) code corrected during adjudication.
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
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.
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
N108	Missing/incomplete/invalid upgrade information.
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.
N11	Denial reversed because of medical review.

Code	Description
N110	This facility is not certified for film mammography.
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
N112	This claim is excluded from your electronic remittance advice.
N113	Only one initial visit is covered per physician, group practice or provider.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
N117	This service is paid only once in a patient's lifetime.
N118	This service is not paid if billed more than once every 28 days.
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days.
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.
N122	Add-on code cannot be billed by itself.
N123	This is a split service and represents a portion of the units from the originally submitted service.
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
N128	This amount represents the prior to coverage portion of the allowance.
N129	Not eligible due to the patient's age.
N13	Payment based on professional/technical component modifier(s).
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
N131	Total payments under multiple contracts cannot exceed the allowance for this service.
N132	Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
N133	Alert: Services for predetermination and services requesting payment are being processed separately.
N134	Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
N135	Record fees are the patient's responsibility and limited to the specified co-payment.
N136	Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
N137	Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.

Code	Description
N138	Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
N139	Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N140	Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
N143	The patient was not in a hospice program during all or part of the service dates billed.
N144	The rate changed during the dates of service billed.
N146	Missing screening document.
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.
N148	Missing/incomplete/invalid date of last menstrual period.
N149	Rebill all applicable services on a single claim.
N15	Services for a newborn must be billed separately.
N150	Missing/incomplete/invalid model number.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.
N154	Alert: This payment was delayed for correction of provider's mailing address.
N155	Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
N156	Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.
N157	Transportation to/from this destination is not covered.
N158	Transportation in a vehicle other than an ambulance is not covered.
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
N160	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.
N161	This drug/service/supply is covered only when the associated service is covered.
N162	Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.
N163	Medical record does not support code billed per the code definition.
N167	Charges exceed the post-transplant coverage limit.
N170	A new/revised/renewed certificate of medical necessity is needed.
N171	Payment for repair or replacement is not covered or has exceeded the purchase price.
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
N173	No qualifying hospital stay dates were provided for this episode of care.
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
N175	Missing review organization approval.
N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
N177	Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
N178	Missing pre-operative images/visual field results.
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
N180	This item or service does not meet the criteria for the category under which it was billed.
N181	Additional information is required from another provider involved in this service.
N182	This claim/service must be billed according to the schedule for this plan.

Code	Description
N183	Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
N184	Rebill technical and professional components separately.
N185	Alert: Do not resubmit this claim/service.
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N188	The approved level of care does not match the procedure code submitted.
N189	Alert: This service has been paid as a one-time exception to the plan's benefit restrictions.
N19	Procedure code incidental to primary procedure.
N190	Missing contract indicator.
N191	The provider must update insurance information directly with payer.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.
N193	Specific Federal/state/local program may cover this service through another payer.
N194	Technical component not paid if provider does not own the equipment used.
N195	The technical component must be billed separately.
N196	Alert: Patient eligible to apply for other coverage which may be primary.
N197	The subscriber must update insurance information directly with payer.
N198	Rendering provider must be affiliated with the pay-to provider.
N199	Additional payment/recoupment approved based on payer-initiated review/audit.
N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
N20	Service not payable with other service rendered on the same date.
N200	The professional component must be billed separately.
N202	Additional information/explanation will be sent separately
N203	Missing/incomplete/invalid anesthesia time/units
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months
N205	Information provided was illegible
N206	The supporting documentation does not match the information sent on the claim.
N207	Missing/incomplete/invalid weight.
N208	Missing/incomplete/invalid DRG code
N209	Missing/incomplete/invalid taxpayer identification number (TIN).
N21	Alert: Your line item has been separated into multiple lines to expedite handling.
N210	Alert: You may appeal this decision
N211	Alert: You may not appeal this decision
N212	Charges processed under a Point of Service benefit
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s)
N215	Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package
N217	We pay only one site of service per provider per claim
N218	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.
N219	Payment based on previous payer's allowed amount.
N22	This procedure code was added/changed because it more accurately describes the services rendered.
N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.
N221	Missing Admitting History and Physical report.
N222	Incomplete/invalid Admitting History and Physical report.
N223	Missing documentation of benefit to the patient during initial treatment period.
N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.
N226	Incomplete/invalid American Diabetes Association Certificate of Recognition.
N227	Incomplete/invalid Certificate of Medical Necessity.

Code	Description
N228	Incomplete/invalid consent form.
N229	Incomplete/invalid contract indicator.
N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
N232	Incomplete/invalid itemized bill/statement.
N233	Incomplete/invalid operative note/report.
N234	Incomplete/invalid oxygen certification/re-certification.
N235	Incomplete/invalid pacemaker registration form.
N236	Incomplete/invalid pathology report.
N237	Incomplete/invalid patient medical record for this service.
N238	Incomplete/invalid physician certified plan of care
N239	Incomplete/invalid physician financial relationship form.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
N240	Incomplete/invalid radiology report.
N241	Incomplete/invalid review organization approval.
N242	Incomplete/invalid radiology film(s)/image(s).
N243	Incomplete/invalid/not approved screening document.
N244	Incomplete/Invalid pre-operative images/visual field results.
N245	Incomplete/invalid plan information for other insurance
N246	State regulated patient payment limitations apply to this service.
N247	Missing/incomplete/invalid assistant surgeon taxonomy.
N248	Missing/incomplete/invalid assistant surgeon name.
N249	Missing/incomplete/invalid assistant surgeon primary identifier.
N250	Missing/incomplete/invalid assistant surgeon secondary identifier.
N251	Missing/incomplete/invalid attending provider taxonomy.
N252	Missing/incomplete/invalid attending provider name.
N253	Missing/incomplete/invalid attending provider primary identifier.
N254	Missing/incomplete/invalid attending provider secondary identifier.
N255	Missing/incomplete/invalid billing provider taxonomy.
N256	Missing/incomplete/invalid billing provider/supplier name.
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
N258	Missing/incomplete/invalid billing provider/supplier address.
N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
N26	Missing itemized bill/statement.
N260	Missing/incomplete/invalid billing provider/supplier contact information.
N261	Missing/incomplete/invalid operating provider name.
N262	Missing/incomplete/invalid operating provider primary identifier.
N263	Missing/incomplete/invalid operating provider secondary identifier.
N264	Missing/incomplete/invalid ordering provider name.
N265	Missing/incomplete/invalid ordering provider primary identifier.
N266	Missing/incomplete/invalid ordering provider address.
N267	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER SECONDARY IDENTIFIER.
N268	Missing/incomplete/invalid ordering provider contact information.
N269	Missing/incomplete/invalid other provider name.
N27	Missing/incomplete/invalid treatment number.
N270	Missing/incomplete/invalid other provider primary identifier.
N271	Missing/incomplete/invalid other provider secondary identifier.
N272	Missing/incomplete/invalid other payer attending provider identifier.
N273	Missing/incomplete/invalid other payer operating provider identifier.
N274	Missing/incomplete/invalid other payer other provider identifier.
N275	Missing/incomplete/invalid other payer purchased service provider identifier.
N276	Missing/incomplete/invalid other payer referring provider identifier.

Code	Description
N277	Missing/incomplete/invalid other payer rendering provider identifier.
N278	Missing/incomplete/invalid other payer service facility provider identifier.
N279	Missing/incomplete/invalid pay-to provider name.
N28	Consent form requirements not fulfilled.
N280	Missing/incomplete/invalid pay-to provider primary identifier.
N281	Missing/incomplete/invalid pay-to provider address.
N282	Missing/incomplete/invalid pay-to provider secondary identifier.
N283	Missing/incomplete/invalid purchased service provider identifier.
N284	Missing/incomplete/invalid referring provider taxonomy.
N285	Missing/incomplete/invalid referring provider name.
N286	Missing/incomplete/invalid referring provider primary identifier.
N287	Missing/incomplete/invalid referring provider secondary identifier.
N288	Missing/incomplete/invalid rendering provider taxonomy.
N289	Missing/incomplete/invalid rendering provider name.
N29	Missing documentation/orders/notes/summary/report/chart.
N290	Missing/incomplete/invalid rendering provider primary identifier.
N291	Missing/incomplete/invalid rendering provider secondary identifier.
N292	Missing/incomplete/invalid service facility name.
N293	Missing/incomplete/invalid service facility primary identifier.
N294	Missing/incomplete/invalid service facility primary address.
N295	Missing/incomplete/invalid service facility secondary identifier.
N296	Missing/incomplete/invalid supervising provider name.
N297	Missing/incomplete/invalid supervising provider primary identifier.
N298	Missing/incomplete/invalid supervising provider secondary identifier.
N299	Missing/incomplete/invalid occurrence date(s).
N3	Missing consent form.
N30	Patient ineligible for this service.
N300	Missing/incomplete/invalid occurrence span date(s).
N301	Missing/incomplete/invalid procedure date(s).
N302	Missing/incomplete/invalid other procedure date(s).
N303	Missing/incomplete/invalid principal procedure date.
N304	Missing/incomplete/invalid dispensed date.
N305	Missing/incomplete/invalid accident date.
N306	Missing/incomplete/invalid acute manifestation date.
N307	Missing/incomplete/invalid adjudication or payment date.
N308	Missing/incomplete/invalid appliance placement date.
N309	Missing/incomplete/invalid assessment date.
N31	Missing/incomplete/invalid prescribing provider identifier.
N310	Missing/incomplete/invalid assumed or relinquished care date.
N311	Missing/incomplete/invalid authorized to return to work date.
N312	Missing/incomplete/invalid begin therapy date.
N313	Missing/incomplete/invalid certification revision date.
N314	Missing/incomplete/invalid diagnosis date.
N315	Missing/incomplete/invalid disability from date.
N316	Missing/incomplete/invalid disability to date.
N317	Missing/incomplete/invalid discharge hour.
N318	Missing/incomplete/invalid discharge or end of care date.
N319	Missing/incomplete/invalid hearing or vision prescription date.
N32	Claim must be submitted by the provider who rendered the service.
N320	Missing/incomplete/invalid Home Health Certification Period.
N321	Missing/incomplete/invalid last admission period.
N322	Missing/incomplete/invalid last certification date.
N323	Missing/incomplete/invalid last contact date.
N324	Missing/incomplete/invalid last seen/visit date.

Code	Description
N325	Missing/incomplete/invalid last worked date.
N326	Missing/incomplete/invalid last x-ray date.
N327	Missing/incomplete/invalid other insured birth date.
N328	Missing/incomplete/invalid Oxygen Saturation Test date.
N329	Missing/incomplete/invalid patient birth date.
N33	No record of health check prior to initiation of treatment.
N330	Missing/incomplete/invalid patient death date.
N331	Missing/incomplete/invalid physician order date.
N332	Missing/incomplete/invalid prior hospital discharge date.
N333	Missing/incomplete/invalid prior placement date.
N334	Missing/incomplete/invalid re-evaluation date
N335	Missing/incomplete/invalid referral date.
N336	Missing/incomplete/invalid replacement date.
N337	Missing/incomplete/invalid secondary diagnosis date.
N338	Missing/incomplete/invalid shipped date.
N339	Missing/incomplete/invalid similar illness or symptom date.
N34	Incorrect claim form/format for this service.
N340	Missing/incomplete/invalid subscriber birth date.
N341	Missing/incomplete/invalid surgery date.
N342	Missing/incomplete/invalid test performed date.
N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.
N345	Date range not valid with units submitted.
N346	Missing/incomplete/invalid oral cavity designation code.
N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.
N349	The administration method and drug must be reported to adjudicate this service.
N35	Program integrity/utilization review decision.
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
N351	Service date outside of the approved treatment plan service dates.
N352	Alert: There are no scheduled payments for this service. Submit a claim for each patient visit.
N353	Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.
N354	Incomplete/invalid invoice
N355	Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.
N356	Not covered when performed with, or subsequent to, a non-covered service.
N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.
N359	Missing/incomplete/invalid height.
N36	Claim must meet primary payer's processing requirements before we can consider payment.
N360	Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.
N362	The number of Days or Units of Service exceeds our acceptable maximum.
N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination.
N364	Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.

Code	Description
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
N37	Missing/incomplete/invalid tooth number/letter.
N370	Billing exceeds the rental months covered/approved by the payer.
N371	Alert: title of this equipment must be transferred to the patient.
N372	Only reasonable and necessary maintenance/service charges are covered.
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf.
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.
N377	Payment based on a processed replacement claim.
N378	Missing/incomplete/invalid prescription quantity.
N379	Claim level information does not match line level information.
N380	The original claim has been processed, submit a corrected claim.
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.
N382	Missing/incomplete/invalid patient identifier.
N383	Not covered when deemed cosmetic.
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
N385	Notification of admission was not timely according to published plan procedures.
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 web access, you may contact the contractor to request a copy of the NCD.
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.
N388	Missing/incomplete/invalid prescription number
N389	Duplicate prescription number submitted.
N39	Procedure code is not compatible with tooth number/letter.
N390	This service/report cannot be billed separately.
N391	Missing emergency department records.
N392	Incomplete/invalid emergency department records.
N393	Missing progress notes/report.
N394	Incomplete/invalid progress notes/report.
N395	Missing laboratory report.
N396	Incomplete/invalid laboratory report.
N397	Benefits are not available for incomplete service(s)/undelivered item(s).
N398	Missing elective consent form.
N399	Incomplete/invalid elective consent form.
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
N40	Missing radiology film(s)/image(s).
N400	Alert: Electronically enabled providers should submit claims electronically.
N401	Missing periodontal charting.
N402	Incomplete/invalid periodontal charting.
N403	Missing facility certification.
N404	Incomplete/invalid facility certification.
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
N407	You are not an approved submitter for this transmission format.
N408	This payer does not cover deductibles assessed by a previous payer.
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
N410	Not covered unless the prescription changes.

Code	Description
N418	Misrouted claim. See the payer's claim submission instructions.
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
N42	No record of mental health assessment.
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program.
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program.
N424	Patient does not reside in the geographic area required for this type of payment.
N425	Statutorily excluded service(s).
N426	No coverage when self-administered.
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.
N428	Not covered when performed in this place of service.
N429	Not covered when considered routine.
N43	Bed hold or leave days exceeded.
N430	Procedure code is inconsistent with the units billed.
N431	Not covered with this procedure.
N432	Adjustment based on a Recovery Audit.
N433	Resubmit this claim using only your National Provider Identifier (NPI)
N434	Missing/Incomplete/Invalid Present on Admission indicator.
N435	Exceeds number/frequency approved /allowed within time period without support documentation.
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made.
N437	Alert: If the injury claim is accepted, these charges will be reconsidered.
N438	This jurisdiction only accepts paper claims
N439	Missing anesthesia physical status report/indicators.
N440	Incomplete/invalid anesthesia physical status report/indicators.
N441	This missed/cancelled appointment is not covered.
N442	Payment based on an alternate fee schedule.
N443	Missing/incomplete/invalid total time or begin/end time.
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.
N445	Missing document for actual cost or paid amount.
N446	Incomplete/invalid document for actual cost or paid amount.
N447	Payment is based on a generic equivalent as required documentation was not provided.
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement
N449	Payment based on a comparable drug/service/supply.
N45	Payment based on authorized amount.
N450	Covered only when performed by the primary treating physician or the designee.
N451	Missing Admission Summary Report.
N452	Incomplete/invalid Admission Summary Report.
N453	Missing Consultation Report.
N454	Incomplete/invalid Consultation Report.
N455	Missing Physician Order.
N456	Incomplete/invalid Physician Order.
N457	Missing Diagnostic Report.
N458	Incomplete/invalid Diagnostic Report.
N459	Missing Discharge Summary.
N46	Missing/incomplete/invalid admission hour.
N460	Incomplete/invalid Discharge Summary.
N461	Missing Nursing Notes.
N462	Incomplete/invalid Nursing Notes.
N463	Missing support data for claim.
N464	Incomplete/invalid support data for claim.
N465	Missing Physical Therapy Notes/Report.
N466	Incomplete/invalid Physical Therapy Notes/Report.

Code	Description
N467	Missing Report of Tests and Analysis Report.
N468	Incomplete/invalid Report of Tests and Analysis Report.
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
N47	Claim conflicts with another inpatient stay.
N470	This payment will complete the mandatory medical reimbursement limit.
N471	Missing/incomplete/invalid HIPPS Rate Code.
N472	Payment for this service has been issued to another provider.
N473	Missing certification.
N474	Incomplete/invalid certification
N475	Missing completed referral form.
N476	Incomplete/invalid completed referral form
N477	Missing Dental Models.
N478	Incomplete/invalid Dental Models
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N48	Claim information does not agree with information received from other insurance carrier.
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N481	Missing Models.
N482	Incomplete/invalid Models
N483	Missing Periodontal Charts.
N484	INCOMPLETE/INVALID PERIODONTAL CHARTS
N485	Missing Physical Therapy Certification.
N486	Incomplete/invalid Physical Therapy Certification.
N487	Missing Prosthetics or Orthotics Certification.
N488	Incomplete/invalid Prosthetics or Orthotics Certification
N489	Missing referral form.
N49	Court ordered coverage information needs validation.
N490	Incomplete/invalid referral form
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.
N493	Missing Doctor First Report of Injury.
N494	Incomplete/invalid Doctor First Report of Injury.
N495	Missing Supplemental Medical Report.
N496	Incomplete/invalid Supplemental Medical Report.
N497	Missing Medical Permanent Impairment or Disability Report.
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.
N499	Missing Medical Legal Report.
N5	EOB received from previous payer. Claim not on file.
N50	Missing/incomplete/invalid discharge information.
N500	Incomplete/invalid Medical Legal Report.
N501	Missing Vocational Report.
N502	Incomplete/invalid Vocational Report.
N503	Missing Work Status Report.
N504	Incomplete/invalid Work Status Report.
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.
N507	Plan distance requirements have not been met.
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.

Code	Description
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
N51	Electronic interchange agreement not on file for provider/submitter.
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.
N516	Records indicate a mismatch between the submitted NPI and EIN.
N517	Resubmit a new claim with the requested information.
N518	No separate payment for accessories when furnished for use with oxygen equipment.
N519	Invalid combination of HCPCS modifiers.
N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
N520	Alert: Payment made from a Consumer Spending Account.
N521	Mismatch between the submitted provider information and the provider information stored in our system.
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.
N524	Based on policy this payment constitutes payment in full.
N525	These services are not covered when performed within the global period of another service.
N526	Not qualified for recovery based on employer size.
N527	We processed this claim as the primary payer prior to receiving the recovery demand.
N528	Patient is entitled to benefits for Institutional Services only.
N529	Patient is entitled to benefits for Professional Services only.
N53	Missing/incomplete/invalid point of pick-up address.
N530	Not Qualified for Recovery based on enrollment information.
N531	Not qualified for recovery based on direct payment of premium.
N532	Not qualified for recovery based on disability and working status.
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.
N534	This is an individual policy, the employer does not participate in plan sponsorship.
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.
N537	We have examined claims history and no records of the services have been found.
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.
N54	Claim information is inconsistent with pre-certified/authorized services.
N540	Payment adjusted based on the interrupted stay policy.
N541	Mismatch between the submitted insurance type code and the information stored in our system.
N542	Missing income verification.
N543	Incomplete/invalid income verification
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.
N547	A refund request (Frequency Type Code 8) was processed previously.
N548	Alert: Patient's calendar year deductible has been met.
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.
N55	Procedures for billing with group/referring/performing providers were not followed.

Code	Description
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.
N552	Payment adjusted to reverse a previous withhold/bonus amount.
N554	Missing/Incomplete/Invalid Family Planning Indicator
N555	Missing medication list.
N556	Incomplete/invalid medication list.
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed.
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.
N567	Not covered when considered preventative.
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.
N569	Not covered when performed for the reported diagnosis.
N57	Missing/incomplete/invalid prescribing date.
N570	Missing/incomplete/invalid credentialing data
N571	Alert: Payment will be issued quarterly by another payer/contractor.
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor.
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.
N576	Services not related to the specific incident/claim/accident/loss being reported.
N577	Personal Injury Protection (PIP) Coverage.
N578	Coverages do not apply to this loss.
N579	Medical Payments Coverage (MPC).
N58	Missing/incomplete/invalid patient liability amount.
N580	Determination based on the provisions of the insurance policy.
N581	Investigation of coverage eligibility is pending.
N582	Benefits suspended pending the patient's cooperation.
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.
N585	Benefits are no longer available based on a final injury settlement.
N586	The injured party does not qualify for benefits.
N587	Policy benefits have been exhausted.
N588	The patient has instructed that medical claims/bills are not to be paid.

Code	Description
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.
N59	Please refer to your provider manual for additional program and provider information.
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).
N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.
N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.
N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.
N598	Health care policy coverage is primary.
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.
N602	Adjusted based on the Redbook maximum allowance.
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.
N607	Service provided for non-compensable condition(s).
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.
N609	80% of the providers billed amount is being recommended for payment according to Act 6.
N61	Rebill services on separate claims.
N610	Alert: Payment based on an appropriate level of care.
N611	Claim in litigation. Contact insurer for more information.
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.
N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.
N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.

Code	Description
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.
N619	Coverage terminated for non-payment of premium.
N62	Dates of service span multiple rate periods. Resubmit separate claims.
N620	Alert: This procedure code is for quality reporting/informational purposes only.
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.
N622	Not covered based on the date of injury/accident.
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.
N624	The associated Workers' Compensation claim has been withdrawn.
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.
N626	New or established patient E/M codes are not payable with chiropractic care codes.
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
N629	Reviews/documentation/notes/summaries/reports/charts not requested.
N63	Rebill services on separate claim lines.
N630	Referral not authorized by attending physician.
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.
N633	Additional anesthesia time units are not allowed.
N634	The allowance is calculated based on anesthesia time units.
N635	The Allowance is calculated based on the anesthesia base units plus time.
N636	Adjusted because this is reimbursable only once per injury.
N637	Consultations are not allowed once treatment has been rendered by the same provider.
N638	Reimbursement has been made according to the home health fee schedule.
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
N64	The “from” and “to” dates must be different.
N640	Exceeds number/frequency approved/allowed within time period.
N641	Reimbursement has been based on the number of body areas rated.
N642	Adjusted when billed as individual tests instead of as a panel.
N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.
N644	Reimbursement has been made according to the bilateral procedure rule.
N645	Mark-up allowance
N646	Reimbursement has been adjusted based on the guidelines for an assistant.
N647	Adjusted based on diagnosis-related group (DRG).
N648	Adjusted based on Stop Loss.
N649	Payment based on invoice.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N650	This policy was not in effect for this date of loss. No coverage is available.
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.
N652	The date of service is before the date of loss.
N653	The date of injury does not match the reported date of loss.
N654	Adjusted based on achievement of maximum medical improvement (MMI).
N655	Payment based on provider's geographic region.
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.
N657	This should be billed with the appropriate code for these services.
N658	The billed service(s) are not considered medical expenses.
N659	This item is exempt from sales tax.
N660	Sales tax has been included in the reimbursement.
N661	Documentation does not support that the services rendered were medically necessary.
N662	Alert: Consideration of payment will be made upon receipt of a final bill.
N663	Adjusted based on an agreed amount.
N664	Adjusted based on a legal settlement.
N665	Services by an unlicensed provider are not reimbursable.
N666	Only one evaluation and management code at this service level is covered during the course of care.
N667	Missing prescription
N668	Incomplete/invalid prescription
N669	Adjusted based on the Medicare fee schedule.

Code	Description
N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
N671	Payment based on a jurisdiction cost-charge ratio.
N672	Alert: Amount applied to Health Insurance Offset.
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.
N674	Not covered unless a pre-requisite procedure/service has been provided.
N675	Additional information is required from the injured party.
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
N677	Alert: Films/Images will not be returned.
N678	Missing post-operative images/visual field results.
N679	Incomplete/Invalid post-operative images/visual field results.
N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
N680	Missing/Incomplete/Invalid date of previous dental extractions.
N681	Missing/Incomplete/Invalid full arch series.
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.
N683	Missing/Incomplete/Invalid prior treatment documentation.
N684	Payment denied as this is a specialty claim submitted as a general claim.
N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.
N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.
N687	Alert: This reversal is due to a retroactive disenrollment. (Note: To be used with claim/service reversal)
N688	Alert: This reversal is due to a medical or utilization review decision. (Note: To be used with claim/service reversal)
N689	Alert: This reversal is due to a retroactive rate change. (Note: To be used with claim/service reversal)
N69	PPS (Prospective Payment System) code changed by claims processing system.
N690	Alert: This reversal is due to a provider submitted appeal. (Note: To be used with claim/service reversal)
N691	Alert: This reversal is due to a patient submitted appeal. (Note: To be used with claim/service reversal)
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication. (Note: To be used with claim/service reversal)
N693	Alert: This reversal is due to a cancelation of the claim by the provider.
N694	Alert: This reversal is due to a resubmission/change to the claim by the provider.
N695	Alert: This reversal is due to incorrect patient financial responsibility information on the initial adjudication.
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment. (Note: To be used with claim/service reversal)
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment. (Note: To be used with claim/service reversal)
N698	Alert: This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage. (Note: To be used with claim/service reversal)
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.
N70	Consolidated billing and payment applies.
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
N705	Incomplete/invalid documentation.
N706	Missing documentation.
N707	Incomplete/invalid orders.
N708	Missing orders.
N709	Incomplete/invalid notes.
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.
N710	Missing notes.
N711	Incomplete/invalid summary.

Code	Description
N712	Missing summary.
N713	Incomplete/invalid report.
N714	Missing report.
N715	Incomplete/invalid chart.
N716	Missing chart.
N717	Incomplete/Invalid documentation of face-to-face examination.
N718	Missing documentation of face-to-face examination.
N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
N721	This service is only covered when performed as part of a clinical trial.
N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.
N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.
N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
N726	A conditional payment is not allowed.
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
N75	Missing/incomplete/invalid tooth surface information.
N76	Missing/incomplete/invalid number of riders.
N77	Missing/incomplete/invalid designated provider number.
N78	The necessary components of the child and teen checkup (EPSDT) were not completed.
N79	Service billed is not compatible with patient location information.
N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
N80	Missing/incomplete/invalid prenatal screening information.
N81	Procedure billed is not compatible with tooth surface code.
N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
N84	Alert: Further installment payments are forthcoming.
N85	Alert: This is the final installment payment.
N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
N87	Home use of biofeedback therapy is not covered.
N88	Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
N89	Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
N9	Adjustment represents the estimated amount a previous payer may pay.
N90	Covered only when performed by the attending physician.
N91	Services not included in the appeal review.
N92	This facility is not certified for digital mammography.
N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
N95	This provider type/provider specialty may not bill this service.
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.

Code	Description
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
R1	REFUND - MEMBER NOT ELIGIBLE ON DATE OF SERVICE
R2	REFUND - SERVICES WERE BILLED IN ERROR
R3	REFUND - SERVICES WERE PREVIOUSLY PAID/DUPLICATE PAYMENT
R4	REFUND - SERVICES WERE COVERED BY WORKMANS COMPENSATION
R5	REFUND - SERVICES WERE COVERED BY AUTO INSURANCE
R6	REFUND - SERVICES WERE COVERED BY PRIMARY CARRIER
R7	REFUND - SERVICES WERE PAID TO WRONG PROVIDER
R8	REFUND - INCORRECT FEE SCHEDULE, BENEFIT, AND/OR COPAY AMOUNT APPLIED
R9	REFUND - SERVICES WERE PAID BY HEALTH PLAN
R10	REFUND - OTHER
R20	RECOUPMENT OF PREVIOUS PAID CLAIM. CLAIM PAID IN ERROR.
Z1	PRICED PER ENHANCED AMBULATORY PROCEDURE GROUPING (EAPG)
Z2	LABS SHOULD BE SENT TO CONTRACTED LAB PROVIDER
Z3	VOIDED CHECK - NO REISSUE
Z4	VOIDED CHECK - SEE NEW CLAIM
Z5	APL/HCPCS CODE REQUIRED ON CLAIM
Z6	BALANCE DOES NOT EXCEED CO-PAYMENT AMOUNT.
Z7	AUTOMATED TEST. ONLY THOSE SERVICES WITH SUPPORTING DOCUMENTATION VERIFYING DIRECT IDENTIFIABLE SERVICES PER AMA GUIDELINES WILL BE CONSIDERED FOR PAYMENT.
Z8	PAID BY HEALTH PLAN AND DEDUCTED FROM CAP
Z9	PAYMENT DENIED - STUDENT HEALTH SERVICES LIABILITY
Z10	FORWARDED TO HEALTH PLAN - CATHOLIC DIRECTIVE
Z11	PAYMENT DENIED - UNITED HEALTH PROGRAM LIABILITY
Z12	PAYMENT DENIED - PATIENT HAS REACHED LIFETIME MAXIMUM FOR TRANSGENDER SERVICES
Z13	PROVIDER SANCTION AMOUNT - REFER TO LETTER FOR DETAILS.
Z14	MEMBER PAID AND WAS REIMBURSED FOR THESE SERVICES.
Z15	COVERED UNDER VFC PROGRAM, PAID BY HFS
Z16	NOT VALID FOR MEDICARE PURPOSES - MEDICARE USES ANOTHER CODE FOR REPORTING OF, AND PAYMENT FOR, THESE SERVICES.
Z17	PAYMENT DENIED - MISSING ORIGINAL PHARMACY RECEIPT.
Z18	PAYMENT DENIED - MISSING ORIGINAL PHARMACY INFORMATION DOCUMENT
Z19	LETTER OF MEDICAL NECESSITY ON FILE
Z20	FORWARDED TO HEALTH PLAN - OUT OF AREA