ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
201	BILLING PROVIDER ID MISSING	1210	The Billing Provider ID or NPI number is missing.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
202	1ST PATIENT REASON FOR VISIT CODE INVALID	7433	1st Patient Reason for Visit is Invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
203	CLIENT I.D. NUMBER MISSING	129	Recipient's ID Number is Missing or Not in Valid Format.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.
204	1ST EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1900	1st External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
207	2ND PATIENT REASON FOR VISIT CODE INVALID	7434	2nd Patient Reason for Visit is Invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
209	DATE PRESCRIBED IS INVALID	242	Prescription Date is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N57	Missing/incomplete/invalid prescribing date.
210	BILLED AMOUNT > 999999.99	210	BILLED AMOUNT > 999999.99	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing/incomplete/invalid charge.
211	REFILL INDICATOR INVALID	1801	REFILL INDICATOR INVALID.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
212	PRESCRIPTION NUMBER IS MISSING/INVALID	3203	Denied. Prescription Number Is Missing Or Invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N388	Missing/incomplete/invalid prescription number.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
215	DATE DISPENSED IS MISSING	1803	DISPENSE DATE OF SERVICE REQUIRED.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N304	Missing/incomplete/invalid dispensed date.
216	DATE DISPENSED IS INVALID	1385	Dispense date of service is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N304	Missing/incomplete/invalid dispensed date.
217	NDC MISSING	217	NDC MISSING	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
218	NDC IS NOT NUMERIC	218	NDC is not numeric	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
223	HEADER QUANTITY DISPENSED IS MISSING	543	Please Indicate Quantity Dispensed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.
224	HEADER QUANTITY DISPENSED IS INVALID	224	Quantity dispensed is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.
225	3RD PATIENT REASON FOR VISIT CODE INVALID	7435	3rd Patient Reason for Visit is Invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
226	DETAIL UNITS BILLED GREATER THAN 9999	226	DETAIL NUMBER OF UNITS BILLED IS GREATER THAN 9,999.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
227	THIRD PARTY PAYMENT AMOUNT INVALID	81	Primary Carrier Pay missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N58	Missing/incomplete/invalid patient liability amount.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
228	BILLING PROVIDER SIGNATURE MISSING	4060	The provider's signature is missing. Complete signature field indicator, or include signature certification page for the dental or UB04 forms.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA70	Missing/incomplete/invalid provider representative signature.
229	SOURCE OF ADMISSION MISSING/INVALID	1291	Valid Source of Admission is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA42	Missing/incomplete/invalid admission source.
231	PERFORMING PROVIDER NUMBER IS MISSING	1209	Rendering Provider is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
233	QUANTITY BILLED MISSING	1830	The units of service are missing or invalid. Enter/Correct the units of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
234	PROCEDURE CODE MISSING	1720	The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
235	PROCEDURE CODE NOT IN VALID FORMAT	1720	The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
236	NDC QUANTITY BILLED > 9999999.999	236	NDC QUANTITY BILLED > 9999999.999	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
237	CLIENT FIRST NAME IS MISSING OR DOES NOT MATCH	614	FIRST NAME IS MISSING OR DOES NOT MATCH MEMBER ID.	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.
238	CLIENT LAST NAME IS MISSING OR DOES NOT MATCH	29	LAST NAME IS MISSING OR DOES NOT MATCH MEMBER ID.	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
239	THE DETAIL "TO" DATE OF SERVICE IS MISSING	4070	The last date of service is missing or invalid. Enter/Correct the last date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
240	DETAIL TDOS DATE IS INVALID	1261	Detail To Date of Service is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
242	SECONDARY DIAGNOSIS CODE INVALID FORMAT	1148	Second Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
244	THIRD DIAGNOSIS CODE INVALID FORMAT	1149	Third Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
245	MISSING OCCURRENCE CODE	1129	Occurrence Code is required when an Occurrence Date is present.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
246	FOURTH DIAGNOSIS CODE INVALID FORMAT	1150	Fourth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED	5310	The detail lines are missing or the maximum number of lines has been exceeded. Enter the detail lines. If the maximum number is exceeded, split the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
248	PLACE OF SERVICE INVALID FORMAT	150	Place of Service is Missing or Invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
249	PLACE OF SERVICE NOT ON FILE	1278	Place of Service code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
250	CLAIM HAS NO DETAILS	5310	The detail lines are missing or the maximum number of lines has been exceeded. Enter the detail lines. If the maximum number is exceeded, split the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
251	FIRST MODIFIER INVALID	3170	The first modifier code is invalid.	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
252	SECOND MODIFIER INVALID	3171	The second modifier code is invalid.	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.
253	THIRD MODIFIER INVALID	1127	The third modifier code is invalid.	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.
255	TENTH DIAGNOSIS INVALID FORMAT	1170	Tenth diagnosis is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
256	ELEVENTH DIAGNOSIS INVALID FORMAT	1171	Eleventh diagnosis is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
257	PRIMARY DIAGNOSIS CODE MISSING - DETAIL	1630	The principal ICD diagnosis code is missing. Enter the ICD diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.
258	PRIMARY DIAGNOSIS CODE MISSING - HEADER	1630	The principal ICD diagnosis code is missing. Enter the ICD diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.
259	DATE BILLED IS MISSING/INVALID	259	DATE BILLED IS MISSING/INVALID.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
260	DTL UNITS BILLED NOT IN VALID FORMAT	1830	The units of service are missing or invalid. Enter/Correct the units of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
261	TOOTH NUMBER MISSING	1800	The tooth number is invalid/missing. Correct the tooth number.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N37	Missing/incomplete/invalid tooth number/letter.
262	TOOTH NUMBER INVALID	1800	The tooth number is invalid/missing. Correct the tooth number.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N37	Missing/incomplete/invalid tooth number/letter.
263	TOOTH SURFACE CODE INVALID	220	Tooth surface is invalid or not indicated.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N75	Missing/incomplete/invalid tooth surface information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
264	DETAIL FDOS IS MISSING	1240	The from date of service is missing or invalid. Enter/Correct the from date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
265	DETAIL FDOS IS INVALID	1240	The from date of service is missing or invalid. Enter/Correct the from date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
266	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES	697	The number of tooth surfaces indicated is insufficient for the procedure code billed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N75	Missing/incomplete/invalid tooth surface information.
267	TWELFTH DIAGNOSIS INVALID FORMAT	1172	Twelfth diagnosis is invalid	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
268	BILLED AMOUNT MISSING	221	The detail billed amount is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
269	DETAIL BILLED AMOUNT INVALID	221	The detail billed amount is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
270	HEADER TOTAL BILLED AMOUNT MISSING	1271	The Total Billed Amount is missing or incorrect.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
271	HEADER TOTAL BILLED AMOUNT INVALID	153	The header total billed amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
272	PRIMARY DIAGNOSIS CODE INVALID FORMAT	1160	Primary Diagnosis Code is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
272	PRIMARY DIAGNOSIS CODE INVALID FORMAT	1160	Primary Diagnosis Code is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.
273	TYPE OF BILL MISSING	4100	The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
274	TYPE OF BILL CODE INVALID	4100	The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
275	ADMIT DATE MISSING	1850	The admission date is missing or invalid. Enter/Correct the admission date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
280	PATIENT STATUS IS MISSING	1267	The Patient Status code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.
281	PATIENT STATUS IS INVALID	1175	The Patient Status Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.
282	COVERED DAYS MISSING	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
283	COVERED DAYS INVALID	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.

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

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

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

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
304	DISCHARGE HOUR INVALID	2451	The discharge hour is invalid. Please correct the discharge hour.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N317	Missing/incomplete/invalid discharge hour.
310	HMO ID INVALID	1824	HMO ID is invalid or not present on encounter claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N245	Incomplete/invalid plan information for other insurance.
313	MISSING INVALID COVERED-NON COVERED DAYS	1920	The medical leave days/non-covered days are missing or invalid. Enter/Correct the number of medical leave days and/or the non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
317	Condition code required for abortion CPTs	931	Condition Code is missing/invalid or incorrect for the Procedure or Revenue Code submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
318	Condition code not allowed for abortion CPTs	931	Condition Code is missing/invalid or incorrect for the Procedure or Revenue Code submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
319	Diagnosis not allowed for abortion CPTs	80	PROCEDURE CODE NOT PAYABLE WITH DIAGNOSIS ENTERED	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
332	ENCOUNTER POS = 21 HOSP ADMIT DATE MISSING/INVALID	2400	Encounter Place of Service is 21 and Hospital Admit Date is Missing or Invalid	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.
339	REVENUE CODE IS MISSING	3751	The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
340	REVENUE CODE IS INVALID	3751	The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
350	NUMBER OF DTLS NOT EQUAL TO HDR DTL COUNT	1740	The number of details is not equal to the header detail count.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
355	5TH DIAGNOSIS CODE INVALID FORMAT	1151	The Fifth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
356	6TH DIAGNOSIS CODE INVALID FORMAT	1152	The Sixth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
357	7TH DIAGNOSIS CODE INVALID FORMAT	1153	The Seventh Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
358	8TH DIAGNOSIS CODE INVALID FORMAT	1154	The Eighth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
359	9TH DIAGNOSIS CODE INVALID FORMAT	1155	The Ninth Diagnosis Code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
360	ADMITTING DIAGNOSIS MISSING	60	Admit Diagnosis is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
361	ADMITTING DIAGNOSIS CODE INVALID	1147	Admit Diagnosis Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.
362	EMERGENCY DIAGNOSIS CODE IS INVALID	362	Emergency diagnosis code is invalid.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
364	PRINCIPAL ICD PROCEDURE DATE MISSING	1301	The Principal ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N303	Missing/incomplete/invalid principal procedure date.
365	PRINCIPAL ICD PROCEDURE DATE INVALID	1301	The Principal ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N303	Missing/incomplete/invalid principal procedure date.
367	1ST OTHER ICD PROCEDURE DATE MISSING	1302	The 1st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
368	1ST OTHER ICD PROCEDURE DATE INVALID	1302	The 1st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
370	2ND OTHER ICD PROCEDURE DATE MISSING	1303	The 2nd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
371	2ND OTHER ICD PROCEDURE DATE INVALID	1303	The 2nd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
373	3RD OTHER ICD PROCEDURE DATE MISSING	1304	The 3rd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
374	3RD OTHER ICD PROCEDURE DATE INVALID	1304	The 3rd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
376	4TH OTHER ICD PROCEDURE DATE MISSING	1305	The 4th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
377	4TH OTHER ICD PROCEDURE DATE INVALID	1305	The 4th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
379	5TH OTHER ICD PROCEDURE DATE MISSING	1306	The 5th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
380	5TH OTHER ICD PROCEDURE DATE INVALID	1306	The 5th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
381	ATTENDING NPI REQUIRED	1390	The attending physician number is missing or invalid. Enter or verify the attending physician's 10-digit NPI number.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N253	Missing/incomplete/invalid attending provider primary identifier.
382	ATTENDING PROVIDER ID IS INVALID - HDR	1390	The attending physician number is missing or invalid. Enter or verify the attending physician's 10-digit NPI number.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N253	Missing/incomplete/invalid attending provider primary identifier.
383	OTHER 1 PROVIDER ID INVALID - HDR	1975	No Match Found for Other 1 NPI	208	National Provider Identifier - Not matched.	N262	Missing/incomplete/invalid operating provider primary identifier.
395	HEADER STATEMENT COVERS PERIOD FDOS MISSING	389	Header From Date of Service is required. Enter the From Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
396	HEADER STATEMENT COVERS PERIOD FDOS INVALID	1334	Header From Date of Service is invalid. Correct the From Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
397	HEADER STMT COVERS PERIOD TDOS MISSING	1336	Header To Date of Service is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
398	STATEMENT COVERS PERIOD TDOS INVALID	1335	Header To Date of Service is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	1830	The units of service are missing or invalid. Enter/Correct the units of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
405	5TH OCCURRENCE CODE INVALID	4085	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
406	6TH OCCURRENCE CODE INVALID	4086	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
407	7TH OCCURRENCE CODE INVALID	4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
408	8TH OCCURRENCE CODE INVALID	4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
409	1ST OCCURRENCE SPAN CODE INVALID	212	The 1st Occurrence Span Code Invalid. Correct the first occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
410	2ND OCCURRENCE SPAN CODE INVALID	193	The 2nd Occurrence Span code is invalid. Correct the 2nd occurrence span code.Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
411	5TH OCCURRENCE CODE DATE MISSING	734	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
412	5TH OCCURRENCE CODE DATE INVALID	734	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
413	6TH OCCURRENCE CODE DATE MISSING	735	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
414	6TH OCCURRENCE CODE DATE INVALID	735	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
415	7TH OCCURRENCE CODE DATE MISSING	4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
416	7TH OCCURRENCE CODE DATE INVALID	4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
417	8TH OCCURRENCE CODE DATE MISSING	4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
418	8TH OCCURRENCE CODE DATE INVALID	4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
419	FDOS FOR 1ST OCCUR SPAN CODE MISSING	1446	The From Date of Service for the First Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
420	FDOS FOR 1ST OCCUR SPAN CODE INVALID	1445	The From Date of Service for the First Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
420	FDOS FOR 1ST OCCUR SPAN CODE INVALID	1445	The From Date of Service for the First Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
421	TDOS FOR 1ST OCCUR SPAN CODE MISSING	1450	The To Date of Service for the First Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
421	TDOS FOR 1ST OCCUR SPAN CODE MISSING	1450	The To Date of Service for the First Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
422	TDOS FOR 1ST OCCUR SPAN CODE INVALID	1449	The To Date of Service for the First Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
422	TDOS FOR 1ST OCCUR SPAN CODE INVALID	1449	The To Date of Service for the First Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
423	FDOS FOR 2ND OCCUR SPAN CODE MISSING	1448	The From Date of Service for the Second Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
423	FDOS FOR 2ND OCCUR SPAN CODE MISSING	1448	The From Date of Service for the Second Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
424	FDOS FOR 2ND OCCUR SPAN CODE INVALID	1447	The From Date of Service for the Second Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
424	FDOS FOR 2ND OCCUR SPAN CODE INVALID	1447	The From Date of Service for the Second Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
425	TDOS FOR 2ND OCCUR SPAN CODE MISSING	1452	The To Date of Service for the Second Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
425	TDOS FOR 2ND OCCUR SPAN CODE MISSING	1452	The To Date of Service for the Second Occurrence Span Code is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
426	TDOS FOR 2ND OCCUR SPAN CODE INVALID	1451	The To Date of Service for the Second Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
426	TDOS FOR 2ND OCCUR SPAN CODE INVALID	1451	The To Date of Service for the Second Occurrence Span Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
434	MEDICARE COINSURANCE AMOUNT INVALID	1230	The Medicare copayment amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N58	Missing/incomplete/invalid patient liability amount.
450	INVALID AREA OF ORAL CAVITY	1136	The Area of the Oral Cavity is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N346	Missing/incomplete/invalid oral cavity designation code.
451	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	452	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
452	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	452	NO MEDICARE COINSURANCE, DEDUCTIBLE OR COPAY DUE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
458	DIAGNOSIS CODE 10-25 INVALID FORMAT	1157	One or more Diagnosis Code(s) is invalid in positions 10 through 25.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
459	DETAIL DIAGNOSIS TREATMENT INDICATOR INVALID	596	The diagnosis indicator is missing or invalid. Enter/Correct the diagnosis indicator. Refer to the Provider Manual or Help Screens for valid indicators	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
461	1ST VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
462	1ST VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
463	1ST VALUE CODE AMOUNT IS MISSING	4091	The 1st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
464	9TH OCCURRENCE CODE INVALID	738	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
465	9TH OCCURRENCE CODE DATE MISSING	738	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
466	9TH OCCURRENCE CODE DATE INVALID	738	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
467	OCCURRENCE SPAN CODE 3-24 INVALID	1441	One or more Occurrence Span Code(s) is invalid in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
468	FDOS FOR SPAN CODE 3-24 MISSING	1443	One or more From Date(s) of Service is missing for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
468	FDOS FOR SPAN CODE 3-24 MISSING	1443	One or more From Date(s) of Service is missing for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
469	FDOS FOR SPAN CODE 3-24 INVALID	1135	One or more From Date(s) of Service is invalid for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
472	TDOS FOR SPAN CODE 3-24 INVALID	1420	One or more To Date(s) of Service is invalid for Occurrence Span Codes in positions three through 24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
474	6TH OTHER ICD PROCEDURE DATE MISSING	1307	The 6th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
475	6TH OTHER ICD PROCEDURE DATE INVALID	1307	The 6th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
478	2ND VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
479	3RD VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
480	4TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
481	5TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
482	6TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
484	7TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
485	8TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
486	9TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
487	10TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
488	11TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
489	12TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
490	2ND VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
491	3RD VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
492	4TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
493	5TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
494	6TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
495	7TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
496	8TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
497	9TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
498	10TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
499	11TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
501	12TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
504	2ND VALUE CODE AMOUNT IS MISSING	4092	The 2nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
506	DATE BILLED AFTER ICN DATE	1156	Billed date is greater than batch date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
507	DTL FDOS IS AFTER THE DTL TDOS	1462	The detail From Date of Service is after the detail To Date of Service. The From Date of Service must be before the last date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
508	HDR BILLED AMT NOT EQUAL TO DTL BILLED AMT SUM	1330	The total claim charge is omitted or out of balance. Re-calculate and correct the total claim charge.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.
508	HDR BILLED AMT NOT EQUAL TO DTL BILLED AMT SUM	1330	The total claim charge is omitted or out of balance. Re-calculate and correct the total claim charge.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.
510	1ST OCCURRENCE SPAN FDOS IS AFTER TDOS	1383	The first occurrence span from date of service is after the to date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M46	Missing/incomplete/invalid occurrence span code(s).
511	2ND OCCURRENCE SPAN FDOS IS AFTER TDOS	1384	The second occurrence span from date of service is after to to date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
511	2ND OCCURRENCE SPAN FDOS IS AFTER TDOS	1384	The second occurrence span from date of service is after to to date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
514	HEADER TDOS AFTER ICN DATE	1457	Header To Date of Service is after the ICN date. The claim was received before the service was rendered. Services must be rendered before claims are submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
515	HEADER FDOS AFTER ICN DATE	1139	Header From Date of Service is after the date of receipt of the claim. The claim was received before the service was rendered.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
516	3RD VALUE CODE AMOUNT IS MISSING	4093	The 3rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
517	4TH VALUE CODE AMOUNT IS MISSING	4094	The 4th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
520	5TH VALUE CODE AMOUNT IS MISSING	4095	The 5th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
521	6TH VALUE CODE AMOUNT IS MISSING	4096	The 6th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
522	7TH VALUE CODE AMOUNT IS MISSING	4097	The 7th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
523	8TH VALUE CODE AMOUNT IS MISSING	4098	The 8th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
524	9TH VALUE CODE AMOUNT IS MISSING	4099	The 9th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
525	10TH VALUE CODE AMOUNT IS MISSING	4101	The 10th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
526	HDR FDOS IS AFTER HDR TDOS	1183	Header From Date of Service is after the Header To Date of Service. The from date of service must be before the last date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid from date(s) of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
527	DETAIL FDOS IS AFTER ICN DATE	56	Detail From Date of Service is after the ICN Date. The claim was received before the service was rendered. Services must be rendered before claims are submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
528	DTL FDOS TDOS BILLED IN ERROR	4360	The detail date of service is missing or invalid. Enter/Correct the detail date of service. The detail dates of service must fall within the header dates of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
531	11TH VALUE CODE AMOUNT IS MISSING	4102	The 11th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
532	12TH VALUE CODE AMOUNT IS MISSING	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
533	10TH OCCURRENCE CODE INVALID	739	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
534	11TH OCCURRENCE CODE INVALID	740	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
535	12TH OCCURRENCE CODE INVALID	741	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
537	13TH OCCURRENCE CODE INVALID	742	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
538	14TH OCCURRENCE CODE INVALID	743	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
539	15TH OCCURRENCE CODE INVALID	744	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
540	16TH OCCURRENCE CODE INVALID	745	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
541	17TH OCCURRENCE CODE INVALID	746	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
542	18TH OCCURRENCE CODE INVALID	747	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
543	19TH OCCURRENCE CODE INVALID	748	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
544	20TH OCCURRENCE CODE INVALID	749	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
546	INVALID ADJUSTMENT CLIENTS MEDICAID ID NOT SUBMIT	1665	Unable To Process Your Adjustment Request. Member ID Not Present.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
546	INVALID ADJUSTMENT CLIENTS MEDICAID ID NOT SUBMIT	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
547	INVALID ADJUSTMENT - FINANCIAL PAYER NOT PRESENT	1666	Unable To Process Your Adjustment Request. Financial Payer Not Indicated.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
547	INVALID ADJUSTMENT - FINANCIAL PAYER NOT PRESENT	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
548	INVALID ADJUSTMENT PROVIDER ID NOT PRESENT	1667	Unable To Process Your Adjustment Request. Provider ID Not Present.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
548	INVALID ADJUSTMENT PROVIDER ID NOT PRESENT	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
549	INVALID ADJUSTMENT TCN NOT FOUND	2430	The TCN to credit is missing or invalid. Enter/Correct the TCN of the original claim to be credited.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
550	DENY INVALID ADJUSTMENTS PRIOR TO CLAIMS ENGINE	115	Unable To Process Your Adjustment Request.	39	Services denied at the time authorization/pre-certification was requested.		
551	MANUALLY PRICED/PAD CLAIM CANNOT BE ADJUSTED	551	Claim cannot be adjusted - Original claim was manually priced or contained a PAD detail. Void claim and resubmit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
552	INVALID ADJUSTMENT CLIENT NOT FOUND	1670	Unable To Process Your Adjustment Request. Member Not Found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
552	INVALID ADJUSTMENT CLIENT NOT FOUND	4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
553	INVALID ADJUSTMENT PROVIDER NOT FOUND	1671	Unable To Process Your Adjustment Request. Provider Not Found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
555	INVALID ADJUSTMENT - MEDICARE ICN NOT FOUND	555	Invalid adjustment - The Medicare ICN number on the adjustment request was not found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
557	ADJ/VOID - PREVIOUS ICN NOT FOUND OR INVALID	1672	Unable To Process Your Adjustment Request. Original Claim ICN Not Found or original claim cannot be adjusted because of one of the following reasons: a) the original claim has already been adjusted; b) the original claim is in a suspended status; c) the original claim has been voided; or d) the original claim is denied.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
558	INVALID ADJUSTMENT - CLAIM HAS BEEN ADJUSTED	1673	Unable To Process Your Adjustment Request. Claim Has Already Been Adjusted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
560	INVALID ADJUSTMENT CLAIM WAITING TO BE ADJUSTED	1674	Unable To Process Your Adjustment Request. A Different Adjustment Is Pending For This Claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N779	Replacement/Void claims cannot be submitted until the original claim has finalized. Please resubmit once payment or denial is received.
561	INVALID ADJUSTMENT CLAIM HAS AN OPEN TPL AR	1675	Unable To Process Your Adjustment Request. This Claim Is In Post Pay Billing For Third Party Liability Payment.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
562	INVALID ADJUSTMENT HIST REGION ADJUST NOT ALLOWED	1676	Unable To Process Your Adjustment Request. Claim Can No Longer Be Adjusted. Contact Provider Services For Further Information.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
563	INVALID ADJUSTMENT CLAIM TYPES DO NOT MATCH	1677	Unable To Process Your Adjustment Request. The Claim Type Of The Adjustment Does Not Match The Claim Type Of The Original Claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
564	INVALID ADJUSTMENT CLIENT IDS DO NOT MATCH	1678	Unable To Process Your Adjustment Request. Member ID Number On The Claim And On The Adjustment Request Do Not Match.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.
566	INVALID ADJUSTMENT PROVIDERS DO NOT MATCH	1679	Unable To Process Your Adjustment Request. Provider NPI Number and/or the Provider Service Location on the original claim and on the adjustment request do not match.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
567	NON-COV DAYS NOT EQ SUM UNITS W/NON-COV ACCOM CHG	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
568	ADMIT DATE GREATER THAN HEADER DISCHARGE DATE	1393	Discharge Date is before the Admission Date. The discharge date cannot be before the admission date. Correct the discharge/admission date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N50	Missing/incomplete/invalid discharge information.
570	HEADER TOTAL DAYS NOT EQUAL TO DAYS BILLED	1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
571	PRIMARY SURGICAL PROCEDURE CODE MISSING	1981	The Principal ICD Procedure code is missing or invalid. Correct the code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
583	10TH OCCURRENCE CODE DATE MISSING	739	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
584	11TH OCCURRENCE CODE DATE MISSING	740	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
588	12TH OCCURRENCE CODE DATE MISSING	741	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
589	SUSPEND ADJUSTMENT FOR PRE-PAYMENT VERIFICATION	1854	1st Cycle Mass Adjustment	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
590	13TH OCCURRENCE CODE DATE MISSING	742	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
591	14TH OCCURRENCE CODE DATE MISSING	743	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
593	15TH OCCURRENCE CODE DATE MISSING	744	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
594	16TH OCCURRENCE CODE DATE MISSING	745	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
595	EXCP CLAIMS SUSPEND FOR REVIEW	167	Required Documentation Has Not Been Submitted.	163	Attachment/other documentation referenced on the claim was not received.	N223	Missing documentation of benefit to the patient during initial treatment period.
595	EXCP CLAIMS SUSPEND FOR REVIEW	1000	Service Requires Special Review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		
597	17TH OCCURRENCE CODE DATE MISSING	746	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
603	ATTACHMENT INDICATED BUT NOT YET RECEIVED	603	ATTACHMENT WAS INDICATED BUT NOT YET RECEIVED. Attachments must be submitted within 35 days of claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
603	ATTACHMENT INDICATED BUT NOT YET RECEIVED	989	Claim Denied. Attachment was not received within 35 days of a claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
604	18TH OCCURRENCE CODE DATE MISSING	747	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
605	FROM DATE IS AFTER TO DATE FOR SPAN OCC. 3-24	605	From Date of Service is after To Date of Service for one or more occurrence spans 3-24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).
605	FROM DATE IS AFTER TO DATE FOR SPAN OCC. 3-24	605	From Date of Service is after To Date of Service for one or more occurrence spans 3-24.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).
607	ATTACHMENT INDICATED BUT NOT YET RECEIVED-INSTIT	607	ATTACHMENT WAS INDICATED BUT NOT YET RECEIVED. Attachments must be submitted within 35 days of claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
607	ATTACHMENT INDICATED BUT NOT YET RECEIVED-INSTIT	989	Claim Denied. Attachment was not received within 35 days of a claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
608	ATTACHMENT INDICATED BUT NOT RECEIVED- DENY	989	Claim Denied. Attachment was not received within 35 days of a claim receipt.	163	Attachment/other documentation referenced on the claim was not received.		
610	19TH OCCURRENCE CODE DATE MISSING	748	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
611	20TH OCCURRENCE CODE DATE MISSING	749	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
612	21ST OCCURRENCE CODE DATE MISSING	750	21st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
613	22ND OCCURRENCE CODE DATE MISSING	751	22nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
614	23RD OCCURRENCE CODE DATE MISSING	752	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
615	24TH OCCURRENCE CODE DATE MISSING	753	24th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
616	10TH OCCURRENCE CODE DATE INVALID	739	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
617	11TH OCCURRENCE CODE DATE INVALID	740	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
618	12TH OCCURRENCE CODE DATE INVALID	741	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
619	13TH OCCURRENCE CODE DATE INVALID	742	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
620	14TH OCCURRENCE CODE DATE INVALID	743	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
621	15TH OCCURRENCE CODE DATE INVALID	744	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
622	16TH OCCURRENCE CODE DATE INVALID	745	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
623	17TH OCCURRENCE CODE DATE INVALID	746	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
624	18TH OCCURRENCE CODE DATE INVALID	747	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
625	19TH OCCURRENCE CODE DATE INVALID	748	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
626	20TH OCCURRENCE CODE DATE INVALID	749	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
627	21ST OCCURRENCE CODE DATE INVALID	750	21st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
628	22ND OCCURRENCE CODE DATE INVALID	751	22nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
629	23RD OCCURRENCE CODE DATE INVALID	752	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).
630	24TH OCCURRENCE CODE DATE INVALID	753	24th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
631	7TH OTHER ICD PROCEDURE DATE MISSING	1308	The 7th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
632	8TH OTHER ICD PROCEDURE DATE MISSING	1309	The 8th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
633	9TH OTHER ICD PROCEDURE DATE MISSING	1310	The 9th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
634	10TH OTHER ICD PROCEDURE DATE MISSING	1311	The 10th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
635	11TH OTHER ICD PROCEDURE DATE MISSING	1312	The 11th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
636	12TH OTHER ICD PROCEDURE DATE MISSING	1313	The 12th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
637	13TH OTHER ICD PROCEDURE DATE MISSING	1314	The 13th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
638	14TH OTHER ICD PROCEDURE DATE MISSING	1315	The 14th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
639	15TH OTHER ICD PROCEDURE DATE MISSING	1316	The 15th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
644	16TH OTHER ICD PROCEDURE DATE MISSING	1317	The 16th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
645	17TH OTHER ICD PROCEDURE DATE MISSING	1318	The 17th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
646	18TH OTHER ICD PROCEDURE DATE MISSING	1319	The 18th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
647	19TH OTHER ICD PROCEDURE DATE MISSING	1320	The 19th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
648	20TH OTHER ICD PROCEDURE DATE MISSING	1321	The 20th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
649	21ST OTHER ICD PROCEDURE DATE MISSING	1322	The 21st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
650	22ND OTHER ICD PROCEDURE DATE MISSING	1323	The 22nd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
651	23RD OTHER ICD PROCEDURE DATE MISSING	1324	The 23rd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
653	24TH OTHER ICD PROCEDURE DATE MISSING	1325	The 24th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
654	7TH OTHER ICD PROCEDURE DATE INVALID	1308	The 7th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
655	8TH OTHER ICD PROCEDURE DATE INVALID	1309	The 8th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
656	9TH OTHER ICD PROCEDURE DATE INVALID	1310	The 9th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
657	10TH OTHER ICD PROCEDURE DATE INVALID	1311	The 10th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
658	11TH OTHER ICD PROCEDURE DATE INVALID	1312	The 11th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
659	12TH OTHER ICD PROCEDURE DATE INVALID	1313	The 12th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
660	13TH OTHER ICD PROCEDURE DATE INVALID	1314	The 13th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
661	14TH OTHER ICD PROCEDURE DATE INVALID	1315	The 14th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
662	15TH OTHER ICD PROCEDURE DATE INVALID	1316	The 15th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
663	16TH OTHER ICD PROCEDURE DATE INVALID	1317	The 16th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
664	17TH OTHER ICD PROCEDURE DATE INVALID	1318	The 17th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
665	18TH OTHER ICD PROCEDURE DATE INVALID	1319	The 18th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
666	19TH OTHER ICD PROCEDURE DATE INVALID	1320	The 19th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
667	20TH OTHER ICD PROCEDURE DATE INVALID	1321	The 20th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
668	21ST OTHER ICD PROCEDURE DATE INVALID	1322	The 21st Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
669	22ND OTHER ICD PROCEDURE DATE INVALID	1323	The 22nd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
670	23RD OTHER ICD PROCEDURE DATE INVALID	1324	The 23rd Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).
671	24TH OTHER ICD PROCEDURE DATE INVALID	1325	The 24th Other ICD Procedure date is missing or invalid. Correct the date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
703	BILLING PERIOD EXCEEDS 90 DAYS	703	Billing Period exceeds 90 days	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
704	PAYMENT REQUEST EXCEEDS 31-DAY BILLING LIMIT	704	Payment Request exceeds 31-day billing limit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.
706	COVERAGE LIMITED TO PREGNANT ADULTS	706	Coverage is limited to pregnant adults.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
707	COVERAGE LIMITED TO MEDICAID COVERED SERVICE	707	Coverage Limited to Medicaid Covered Service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
708	HCPCS PROCEDURE REQUIRES A VALID NDC	39	The National Drug Code (NDC) is missing or invalid. The NDC is required for physician- administered drugs.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
709	PROVIDER TYPE/SPECIALTY IS NOT ALLOWED TO BILL NDC	709	Provider Type/Specialty is not allowed to bill NDC.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
710	13TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
711	14TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
712	15TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
713	16TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
714	17TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
715	18TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
716	19TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
717	20TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
718	21ST VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
719	22ND VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
720	23RD VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
721	24TH VALUE CODE IS INVALID	1137	Value Code is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
723	13TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
724	14TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
725	15TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
726	16TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
727	17TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
728	18TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
729	19TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
730	20TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
731	21ST VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
732	22ND VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
733	23RD VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
734	24TH VALUE CODE AMOUNT IS INVALID	1138	Value Code amount is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
735	13TH VALUE CODE AMOUNT IS MISSING	4104	The 13th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
736	14TH VALUE CODE AMOUNT IS MISSING	4105	The 14th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
737	15TH VALUE CODE AMOUNT IS MISSING	4106	The 15th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
738	16TH VALUE CODE AMOUNT IS MISSING	4107	The 16th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
739	17TH VALUE CODE AMOUNT IS MISSING	4108	The 17th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
740	18TH VALUE CODE AMOUNT IS MISSING	4109	The 18th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
741	19TH VALUE CODE AMOUNT IS MISSING	4111	The 19th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
742	20TH VALUE CODE AMOUNT IS MISSING	4112	The 20th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
743	21ST VALUE CODE AMOUNT IS MISSING	4113	The 21st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
744	22ND VALUE CODE AMOUNT IS MISSING	4114	The 22nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
745	23RD VALUE CODE AMOUNT IS MISSING	4115	The 23rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
746	24TH VALUE CODE AMOUNT IS MISSING	4116	The 24th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).
749	EVV SERVICES MUST BE SUBMITTED THROUGH AN EVV SYST	1749	NEW EVV CLAIMS MUST COME THROUGH AN EVV SYSTEM	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
751	Aid Code Not Eligible for service billed	4820	Recipient's aid code is not eligible for procedure code	204	This service/equipment/drug is not covered under the patients current benefit plan		
752	ESRD services included in the global procedure	1754	Procedure Included in Global Procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
753	PAD detail not payable based on patient age	3280	The client's age is invalid for this procedure code. Verify the client's birth date/procedure code.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
754	PAD detail included in payment for another service	1754	Procedure Included in Global Procedure.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
755	Procedure submitted with NDC when not required	1755	NDC submitted for a procedure which does not require an NDC.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N846	National Drug Code (NDC) supplied does not correspond to the HCPCs/CPT billed.
756	Service not covered by Nevada Medicaid	3340	Service not covered by NV Medicaid.	204	This service/equipment/drug is not covered under the patients current benefit plan		
757	Provider not allowed to bill PAD	757	PROVIDER NOT ALLOWED TO BILL FOR PAD SERVICES	299	The billing provider is not eligible to receive payment for the service billed.		
758	NDC not payable by Nevada Medicaid	758	NDC is excluded for Nevada Medicaid	204	This service/equipment/drug is not covered under the patients current benefit plan		
759	FEMALE GENDER RESTRICTION FOR NDC	759	GENDER RESTRICTION FOR NDC	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.
760	NDC not payable based on patient age	760	Age Restriction on NDC	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
761	NDC included VFC	3400	MEDICAID CANNOT PAY FOR VACCINES AVAILABLE THROUGH VFC	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M41	We do not pay for this as the patient has no legal obligation to pay for this.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
762	MALE GENDER RESTRICTION FOR NDC	759	GENDER RESTRICTION FOR NDC	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.
763	NDC is part of inner pack	763	The NDC submitted on the claim detail is part of an inner pack. The NDC needs to be the correct NDC for the drug.	204	This service/equipment/drug is not covered under the patients current benefit plan		
764	Procedure not payable for diagnosis	80	PROCEDURE CODE NOT PAYABLE WITH DIAGNOSIS ENTERED	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
765	Quantity Billed is restricted for this Drug Code	765	Quantity Billed is restricted for this Drug Code.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
766	Liquid Unit Dose drugs are not covered	758	NDC is excluded for Nevada Medicaid	204	This service/equipment/drug is not covered under the patients current benefit plan		
802	CLAIM FREQUENCY CODE NOT VALID FOR ADJUSTMENTS	802	Claim Frequency Code Is not valid for adjustments.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
809	ADMIT DATE ON OR AFTER ICN DATE	1395	Admission Date is on or after Date of Receipt of Claim. The Admission Date cannot be on or after the Date of Receipt on the Claim. Correct the Admission Date	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
817	DETAIL TDOS NOT WITHIN HEADER RANGE	3314	Denied. Detail Dates Are Not Within Statement Covered Period.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
819	ADMIT DATE NOT EQUAL TO HEADER FDOS	719	Admission Date does not match Header From Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.
841	OTHER INSURANCE SUSPECT	78	Other Insurance Suspect - Please verify that the Other Insurance information/payments are entered correctly.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N48	Claim information does not agree with information received from other insurance carrier.
851	PRINCIPAL DIAG POA CODE IS MIS/INVALID	578	Principal Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
853	HCPCS - ANNUAL UPDATE - SUSPEND CLAIMS	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
856	Procedure code requires attachment	847	NOT CURRENTLY IN USE FOR EDIT 856 Detailed description of items delivered needs to correspond to the claim.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	849	The date of service on the claim and recipient?s date and time of acceptance/delivery must correspond.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	851	The provider NPI on the claim must correspond with the provider name on the delivery receipt.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	854	The recipient?s name on the claim must correspond with the recipient?s name on the delivery receipt.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
856	Procedure code requires attachment	855	The quantity of dentures/partials billed on the claim must correspond with the quantity on the delivery receipt	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
856	Procedure code requires attachment	856	Receipt of Dentures/Partials requires a complete, legible attachment.	163	Attachment/other documentation referenced on the claim was not received.		
866	NDC OBSOLETE	2040	NDC is obsolete for the date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N847	National Drug Code (NDC) billed is obsolete.
867	NDC NOT ELIGIBLE	867	NDC NOT ELIGIBLE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
868	HCPCS/NDC NOT A REBATABLE DRUG	1814	NDC NOT A REBATABLE DRUG	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
869	HCPCS/NDC DESI VALUE EQUAL TO 5/6	869	NDC submitted is less than effective.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
870	HCPCS PROCEDURE REQUIRES A VALID NDC	39	The National Drug Code (NDC) is missing or invalid. The NDC is required for physician- administered drugs.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
871	HCPCS/NDC COMBINATION NOT VALID	1199	One or more of the NDCs submitted is not related to the procedure code billed.	204	This service/equipment/drug is not covered under the patients current benefit plan		
886	PRINCIPAL DIAGNOSIS OPPC	3291	THE PRINCIPAL DIAGNOSIS IS A CMS-DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
888	CLAIM FILING VALUE NOT ALLOWED	3029	Claim filing value is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
892	DUPLICATE OTHER PAYER IDENTIFIERS	1002	DUPLICATE OTHER PAYER IDENTIFIERS	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M56	Missing/incomplete/invalid payer identifier.
900	PROVIDER TYPE SPECIALTY GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
902	PROCEDURE CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
903	DIAGNOSIS CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
906	ICD PROCEDURE CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
906	ICD PROCEDURE CODE GROUP NOT FOUND	9999	Processed Per Policy	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
910	BENEFIT PLAN GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
911	INTERNAL ERROR	3581	System Error - Parameter Not Found For DOS	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		
912	MODIFIER CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
913	REVENUE CODE GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
914	TOB GROUP NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
934	CLIA LAB CODE NOT FOUND FOR PROCEDURE CODE	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
941	THE HMO PAID DATE IS INVALID	2401	The HMO Paid Date is invalid. A valid other payer date is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N307	Missing/incomplete/invalid adjudication or payment date.
943	NEGATIVE ALLOWED AMOUNT	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
944	2ND EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1901	2nd External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
945	3RD EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1902	3rd External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
946	4TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1903	4th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
947	5TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1904	5th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
948	6TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1905	6th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
949	7TH EXTERNAL CAUSE OF INJURY DIAGNOSIS INVALID	1906	7th External Cause of Injury Code is invalid. Correct the external cause of injury code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1000	BILLING PROVIDER I.D. NOT ON FILE	352	The billing provider number is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
1002	RENDERING PROVIDER NOT ELIGIBLE	1284	Rendering Provider is not certified for the From Date of Service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1003	BILLING PROV NOT ELIG AT SERV LOC ON DTL DOS	3120	The billing provider is not eligible on date(s) of service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
1007	RENDERING PROV NUM/SVC LOCATION NOT ON FILE	1504	Performing Provider number is not found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1008	BILLING PROV IS NOT A GRP/PERFORMING IS A GRP PROV	1508	Billing Provider cannot be an Individual Provider or Servicing Provider cannot be a Group Provider.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N799	Submitted identifier must be an individual identifier, not group identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1009	CONTRACT COULD NOT BE DETERMINED - DTL	1009	A billing provider contract could not be assigned to this claim. Please refer to the provider billing manuals for guidelines about correct billing information and that you are using the correct billing provider ID. Please make sure that the billing provider has been revalidated and that you are using the correct billing provider service location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110	The rendering provider is not a group member. Verify the rendering provider number/group number.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N55	Procedures for billing with group/referring/performing providers were not followed.
1011	CONTRACT COULD NOT BE DETERMINED - HDR	1011	A billing provider contract could not be assigned to this claim. Please refer to the provider billing manuals for guidelines about correct billing information and that you are using the correct billing provider ID. Please make sure that the billing provider has been revalidated and that you are using the correct billing provider service location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
1012	ATTENDING PROV NOT ENROLLED	12	The attending provider is not enrolled in any provider contract on the FDOS of the claim, or the provider ID is not valid on the FDOS of the claim.	283	Attending provider is not eligible to provide direction of care.	N767	The Medicaid state requires provider to be enrolled in the members Medicaid state program prior to any claim benefits being processed.
1022	REFERRING NPI REQUIRED	1024	A valid referring provider NPI is required.	208	National Provider Identifier - Not matched.	N286	Missing/incomplete/invalid referring provider primary identifier.
1024	PROVIDER NOT LISTED AS CLIENT LOC PROV	776	The provider is not listed as the recipient's level of care provider or is not listed for these dates of service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N450	Covered only when performed by the primary treating physician or the designee.
1026	HEADER REFERRING PROVIDER NPI INVALID	1345	Submitted referring provider NPI in the header is invalid.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1027	REF PROV NPI REQUIRED AND NOT VALID	1376	Submitted referring provider NPI in the detail is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N286	Missing/incomplete/invalid referring provider primary identifier.
1028	REF PROV NOT REQUIRED BUT SUBMITTED AND NOT VALID	718	Referring Provider ID is not required for this service and Referring Provider ID is invalid.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.
1030	NURSING FACILITY NPI REQUIRED - HOSPICE LTC CLAIMS	1030	A Nursing Facility NPI is required for Hospice LTC claims.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
1032	RENDERING NPI INACTIVE	1976	Rendering NPI Inactive	208	National Provider Identifier - Not matched.		
1035	NO MATCH FOUND FOR OTHER 1 NPI	1975	No Match Found for Other 1 NPI	208	National Provider Identifier - Not matched.	N262	Missing/incomplete/invalid operating provider primary identifier.
1036	UNIQUE PROV NOT FOUND FOR OTHER 1 NPI	1977	Unique Provider Service Location could not be found for Other 1 NPI - Detail	208	National Provider Identifier - Not matched.	N262	Missing/incomplete/invalid operating provider primary identifier.
1041	NO MATCH FOUND FOR OTHER 2 NPI	1965	No match found for Other 2 NPI	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N262	Missing/incomplete/invalid operating provider primary identifier.
1044	ATTENDING PROV NPI REQUIRED AND NOT VALID	1044	The submitted Attending Provider ID is not a valid NPI.	208	National Provider Identifier - Not matched.	N253	Missing/incomplete/invalid attending provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1047	PROVIDER TERMINATED - DTL PERFORMING	205	Detail Rendering Provider is no longer enrolled for the Date of Service	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
1048	PROVIDER TERMINATED - DTL DOS	25	Billing or Rendering Provider is no longer enrolled for the From Date of Service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
1051	PERFORMING PROVIDER NOT ON PROVIDER DATABASE	1504	Performing Provider number is not found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1052	OTHER-2 PROVIDER ID - HDR MISSING/NOT VALID	1965	No match found for Other 2 NPI	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N262	Missing/incomplete/invalid operating provider primary identifier.
1062	ORDERING NPI REQUIRED	1062	Ordering NPI is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N265	Missing/incomplete/invalid ordering provider primary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1063	ORDERING PROVIDER NPI REQUIRED AND NOT VALID	1063	Ordering Provider NPI is required and not valid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1064	ORDERING PROVIDER NPI NOT REQUIRED AND NOT VALID	1064	Ordering Provider NPI was not required and not valid.	208	National Provider Identifier - Not matched.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1070	PROCEDURE MISSING ON OUTPATIENT CLAIM	1464	Procedure Missing On Outpatient Claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
1071	ATTENDING PROV CANNOT BE A GROUP OR ORGANIZATION	1071	Attending Provider cannot be a Group or Organization.	283	Attending provider is not eligible to provide direction of care.	N799	Submitted identifier must be an individual identifier, not group identifier.
1076	PROV CONTRACT NOT VALID ON DOS - DTL	1012	Billing Provider Not Eligible on DOS.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1077	PROV CONTRACT NOT VALID ON DOS- HDR	1012	Billing Provider Not Eligible on DOS.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1079	REFERRING PROV CANNOT BE A GROUP OR ORGANIZATION	1360	Referring Provider cannot be a Group Provider	183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N799	Submitted identifier must be an individual identifier, not group identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1082	REFERRING NPI CANNOT BE THE SAME AS SERVICING NPI	92	Referring NPI cannot be the same as the servicing NPI	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N55	Procedures for billing with group/referring/performing providers were not followed.
1548	DATE OF LAST SERVICE GREATER THAN ICN DATE	57	Detail To Date of Service is after the ICN Date. The claim was received before the service was rendered. Services must be rendered before claims are submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid to date(s) of service.
1799	CHARGES SPAN TWO OF PROVIDERS FISCAL YEARS	1655	Charges span two of provider's fiscal years. A split claim is required when the service dates on the claim overlap the provider's fiscal years.	204	This service/equipment/drug is not covered under the patients current benefit plan		
1801	BILLING AND SERVICING PROVIDER ARE DIFFERENT	678	Billing and Servicing provider are different	208	National Provider Identifier - Not matched.		
1802	BILLING PROV NOT ELIGIBLE FOR PARTIAL DOS	720	Billing Provider is not certified for the Date(s) of Service.	242	Services not provided by network/primary care providers.	N95	This provider type/provider specialty may not bill this service.
1803	RENDERING PROV NOT ELIGIBLE FOR PARTIAL DOS	1284	Rendering Provider is not certified for the From Date of Service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N570	Missing/incomplete/invalid credentialing data.
1898	ENCOUNTER - PROVIDER NAME MISSING	2415	ENCOUNTER - Provider Name Missing.	206	National Provider Identifier - missing.		
1900	TAXONOMY IS INVALID BILLING PROVIDER - HDR	1505	The Billing Provider's taxonomy code in the header is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N255	Missing/incomplete/invalid billing provider taxonomy.

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1943	INVALID INTERNAL RENDERING PROV SPECIFIED - DTL	943	RENDERING PROVIDER IS NOT FOUND. PLEASE MAKE SURE THAT THE RENDERING PROVIDER HAS BEEN REVALIDATED, THAT THE RENDERING PROVIDER IS AFFILIATED WITH YOUR BILLING GROUP AND THAT YOU ARE USING THE CORRECT RENDERING PROVIDER ID.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1944	INVALID REFERRING PROV SPECIFIED - DTL	3461	The referring provider number is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N276	Missing/incomplete/invalid other payer referring provider identifier.
1944	INVALID REFERRING PROV SPECIFIED - DTL	3461	The referring provider number is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N286	Missing/incomplete/invalid referring provider primary identifier.
1945	MULTI PROV LOCS FOR BILLING PROV SPEC - HDR	1208	Multiple Service Locations Found For the Billing Provider NPI	208	National Provider Identifier - Not matched.	N77	Missing/incomplete/invalid designated provider number.
1946	MULTI PROV LOCS FOR PERFORMING PROV SPEC - HDR	1978	Unique Provider Service Location could not be found for Rendering NPI	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N294	Missing/incomplete/invalid service facility primary address.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1948	MULTI PROV LOCS FOR FACILITY PROV SPEC - HDR	1500	Multiple Service Locations found for Facility Provider NPI.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
1950	MULTI PROV LOCS FOR OTHER PROV SPEC - HDR	1501	Multiple Service Locations found for Other Provider NPI.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
1951	MULTI PROV LOCS FOR OTHER PROV SPEC - DTL	1502	Multiple Service Locations found for Other Provider NPI - Detail	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
1952	MULTI PROV LOCS FOR RENDERING PROV SPEC - DTL	971	Multiple Service Provider Locations were found for the Rendering Provider. Please verify the rendering provider. For questions, contact Provider Services.	208	National Provider Identifier - Not matched.		
1954	HEADER RENDERING NPI INVALID	1288	Submitted rendering provider NPI in the header is invalid.	208	National Provider Identifier - Not matched.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1955	DETAIL RENDERING PROVIDER ID INVALID	1375	Submitted rendering provider NPI in the detail is invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1956	NO BILLING PROVIDER LOCATION STATUS FOUND	956	No billing provider location status found for date of service range. Please make sure the billing provider has been revalidated and that you are using the correct provider id.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
1958	NO BILLING PROVIDER LOCATION STATUS FOR DOS RANGE	956	No billing provider location status found for date of service range. Please make sure the billing provider has been revalidated and that you are using the correct provider id.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
1960	NO PROVIDER BILLING INDICATOR FOUND	1960	No Provider Billing Indicator Found.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1961	MORE THAN ONE PROVIDER BILLING INDICATOR	1961	Unable to determine provider's billing status. Please contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
1962	NO PROVIDER BILLING INDICATOR FOR DOS RANGE	962	Unable to determine whether a provider is a biller, renderer, or OPR provider for the date of service range. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
1962	NO PROVIDER BILLING INDICATOR FOR DOS RANGE	962	Unable to determine whether a provider is a biller, renderer, or OPR provider for the date of service range. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
1963	RENDERING PROVIDER IS NOT DESIGNATED TO RENDER	175	Rendering Provider indicated is not certified as a rendering provider.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N767	The Medicaid state requires provider to be enrolled in the members Medicaid state program prior to any claim benefits being processed.
1964	BILLING PROVIDER IS NOT DESIGNATED AS A BILLER	1509	Billing Provider indicated is not certified as a billing provider.	243	Services not authorized by network/primary care providers.	N95	This provider type/provider specialty may not bill this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1965	RENDERING REQUIRED AND RENDERING IS NOT PRESENT	1503	A Rendering Provider number is required.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.
1966	NO REND PROVIDER LOCATION STATUS FOUND	966	No Rendering Provider Location Status (In/Out of State) information is found. Please verify the rendering provider. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
1967	MORE THAN ONE REND PROVIDER LOCATION STATUS	967	Conflicting Rendering Provider Location Status (In/Out of State). Please verify the rendering provider. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
1968	NO REND PROVIDER LOCATION STATUS FOR DOS RANGE	968	Conflicting Rendering Provider Location Status (In/Out of State). Please verify the rendering provider. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1970	MULTI SVC LOCATIONS - BILLING PROVIDER NPI	970	Multiple Service Provider Locations were found for the Billing Provider NPI. Please verify the billing provider. For questions, contact Provider Services.	208	National Provider Identifier - Not matched.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
1971	MULTI SVC LOCATIONS - RENDERING PROVIDER NPI HDR	971	Multiple Service Provider Locations were found for the Rendering Provider. Please verify the rendering provider. For questions, contact Provider Services.	208	National Provider Identifier - Not matched.		
1972	MULTI SERVICE LOCATIONS FOR FACILITY PROVIDER NPI	972	Multiple Service Provider Locations were found for the Facility Provider NPI. Please verify the rendering provider. For questions, contact Provider Services.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N293	Missing/incomplete/invalid service facility primary identifier.
1973	MULTI SVC LOCATIONS - RENDERING PROVIDER NPI DTL	971	Multiple Service Provider Locations were found for the Rendering Provider. Please verify the rendering provider. For questions, contact Provider Services.	208	National Provider Identifier - Not matched.		
1974	OPR PROV NOT ENROLLED	30	Prescribing/referring/ordering provider is not currently enrolled.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.
1975	REF/PRESCRIB PROVIDER RSTCN ON BILLING RULE	975	A valid enrolled prescribing, referring or ordering provider is required to bill this service.	183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N808	Not covered for this provider type / provider specialty.
1976	REF/PRESCRIB PT/PS RSTCN ON BILLING RULE	976	The procedure is not billable with the prescribing/referring or ordering provider's specialty.	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N808	Not covered for this provider type / provider specialty.
1977	OPR PROV NOT ENROLLED	30	Prescribing/referring/ordering provider is not currently enrolled.	207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.
1981	NPI REQUIRED HEALTHCARE = Y ORDERING PROV-DETAIL	981	A National Provider Identifier (NPI) is required for the Ordering Provider listed in the detail.	206	National Provider Identifier - missing.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1982	INVALID ORDERING PROVIDER - DETAIL	1025	A valid enrolled ordering provider NPI is required.	208	National Provider Identifier - Not matched.	N265	Missing/incomplete/invalid ordering provider primary identifier.
1996	REND PROV ID NOT EFFECTIVE FOR DOS - DTL	205	Detail Rendering Provider is no longer enrolled for the Date of Service	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
1999	BILLING PROV ID NOT EFFECTIVE FOR DOS - HDR	3120	The billing provider is not eligible on date(s) of service.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
2001	RECIPIENT ID NUMBER NOT ON FILE	1298	Member ID is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.
2003	CLIENT INELIGIBLE ON DTL DOS	3006	Denied. Member Not Eligibile For All/partial Dates. Please Rebill Only Covered Dates.	31	Patient cannot be identified as our insured.		
2012	RECIPIENT BIRTHDATE AFTER FDOS	272	The Admit Date on the claim is prior to the client's Date of Birth. Re-submit claim with an Admit Date equal to or greater than the client's Date of Birth.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
2016	GENDER CONFLICT - UNBORNS	10	Denied. A gender and/or DOB update is required. Recipient must call caseworker to get the information updated first before resubmitting the claim.	7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
2017	CLIENT SERVICES COVERED BY HMO PLAN	38	The member is enrolled in a Medicaid Managed Care Plan. The service requested is covered by the Medicaid Managed Care Plan.	22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.
2027	CLIENT SERVICES COVERED BY DBA PLAN	227	Client Services Covered by DBA Plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2030	Psychiatric Hospital Inpatient Age Restriction	282	Inpatient psychiatric services are not reimbursable for recipients age 21 - 64 (age 22 if receiving services prior to 21st birthday). Effective 8/1/23: PT 13 instructed to split bill if a revenue code in Revenue Group 2002 is billed with a revenue code not included in the group. If a claim is not split billed (i.e., billed on a separate claim), the entire claim will deny.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
2043	CLIENT ON REVIEW	222	Suspended for recipient review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
2054	UNABLE TO DETERMINE CLIENT AID CATEGORY	174	Unable to determine client aid category.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
2057	CLIENT NOT ELIGIBLE ON ALL DATES OF SERVICE-DTL	2710	The client is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
2077	CLIENT NOT ELIGIBLE ON ALL DATES OF SERVICE-HDR	2710	The client is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
2500	CLIENT COVERED BY MEDICARE A	2590	The client has Medicare. Charges must billed to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits.	22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2502	CLIENT COVERED BY MEDICARE B	2590	The client has Medicare. Charges must billed to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits.	22	This care may be covered by another payer per coordination of benefits.	MA92	Missing plan information for other insurance.
2503	FOUND CARRIER - TPL AMOUNT SUBMITTED	2503	HMS IDENTIFIED CLIENT COVERED BY PRIVATE INSURANCE	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.
2504	CLIENT COVERED BY PRIVATE INSURANCE	1248	Client covered by Private Insurance.Please resubmit claim with appropriate cla im adjustment reason code (CARC).on the claim.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
2504	CLIENT COVERED BY PRIVATE INSURANCE	1249	Client Covered by Private Insurance.	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.
2509	Client Covered by Private Insurance Original claim	1249	Client Covered by Private Insurance.	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.
2513	MEDICARE A EXHAUST WITH NO PART B	2513	MEDICARE A EXHAUST WITH NO PART B.	22	This care may be covered by another payer per coordination of benefits.	N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
2531	NO MEDICARE A COVERAGE ON FILE FOR RECIPIENT	2531	Claim suspended for No Medicare Coverage on File for Recipient.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
2603	LOCK-IN VIOLATION	2730	The client is in the Locked-in program. The Lock-in provider number must be either the billing or rendering number on the claim. For institutional claims, the billing provider must be the lock-in provider.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M62	Missing/incomplete/invalid treatment authorization code.
2801	Medicaid, NCU Benefit plans not billable on same c	2801	Medicaid and Nevada Check-Up Benefit plans may not be billed on the same claim. Please rebill denied details on a separate claim	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.		
3000	UNITS EXCEED AUTHORIZED UNITS ON PRIOR AUTH	1526	Services billed exceed PA amount.	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
3001	PRIOR AUTHORIZATION NOT FOUND	192	Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim.	197	Precertification/authorization/notification/pre-treatment absent.		
3003	PRIOR AUTH IS DENIED	518	There is no valid PA on file for this item. The PA is denied, inactive, or rejected. Submit a PA for this service. When approved, enter the prior authorization number on the claim.	197	Precertification/authorization/notification/pre-treatment absent.		
3004	PRIOR AUTH LINE ITEM STATUS DENY	518	There is no valid PA on file for this item. The PA is denied, inactive, or rejected. Submit a PA for this service. When approved, enter the prior authorization number on the claim.	197	Precertification/authorization/notification/pre-treatment absent.		
3006	PA DOLLARS EXCEEDED	1524	Billed amount exceeds PA amount.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre-certified/authorized services.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3008	PRIOR AUTH SERVICE CONFLICT	3008	The prior authorization does not match the services billed on your claim or there are no remaining units available for the line item. Please correct services or submit a new prior authorization for the services billed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre-certified/authorized services.
3009	PARTIAL PA FOUND	399	Date Of Service Must Fall Between The Prior Authorization Start Date and Prior Authorization End Date.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre-certified/authorized services.
3014	ALLOWED AMOUNT ZERO WITH PRICING PA	314	Allowed Amount of Zero with Pricing PA.	287	Referral exceeded	N45	Payment based on authorized amount.
3026	MODIFIER DOES NOT MATCH PA	504	There is no PA on file for the procedure with the billed modifier. Check the approved PA and verify the procedure and modifier.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
3030	PROVIDER ID ON CLAIM DOES NOT MATCH PA	4	The provider on this payment request is not the provider on the approved PA.	119	Benefit maximum for this time period or occurrence has been reached.		
3031	PROVIDER ID ON CLAIM DOES NOT MATCH PBM PA	3031	The provider on this payment request is not the provider on the approved PA. Work with the PBM vendor to correct provider information.	119	Benefit maximum for this time period or occurrence has been reached.		
3032	TOOTH CODE BILLED DOES NOT MATCH PA	505	Tooth Code on claim does not match tooth code on Prior Authorization Request.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre-certified/authorized services.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3033	TOOTH SURFACE BILLED DOES NOT MATCH PA	506	Surface code on claim does not match surface code on Prior Authorization Request.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre-certified/authorized services.
3042	RECIPIENT NUMBER BILLED DOES NOT MATCH PA	2	Recipient ID on claim does not match Recipient ID on Prior Authorization Request.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with pre-certified/authorized services.
3200	2ND DIAGNOSIS OPPC	3292	THE 1ST OTHER DIAGNOSIS IS A CMS-DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3201	3RD DIAGNOSIS OPPC	3293	THE 2ND OTHER DIAGNOSIS IS A CMS-DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3202	4TH DIAGNOSIS OPPC	3294	THE 3RD OTHER DIAGNOSIS IS A CMS-DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3203	5TH DIAGNOSIS OPPC	3296	THE 4TH OTHER DIAGNOSIS IS A CMS-DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3204	6TH DIAGNOSIS OPPC	3298	THE 5TH OTHER DIAGNOSIS IS A CMS-DEFINED OTHER PROVIDER PREVENTABLE CONDITION (OPPC). CMS DOES NOT ALLOW REIMBURSEMENT WHEN AN OPPC IS PRESENT.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3205	7TH DIAGNOSIS OPPC	3300	The 6th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3206	8TH DIAGNOSIS OPPC	3302	The7th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3207	9TH DIAGNOSIS OPPC	3304	The 8th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3208	10TH DIAGNOSIS OPPC	3306	The 9th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3209	11TH DIAGNOSIS OPPC	3312	The 10th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3210	12TH DIAGNOSIS OPPC	3318	The 11th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3211	13TH DIAGNOSIS OPPC	3324	The 12th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3212	14TH DIAGNOSIS OPPC	3330	The 13th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3213	15TH DIAGNOSIS OPPC	3336	The 14th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3214	16TH DIAGNOSIS OPPC	3342	The 15th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
3215	17TH DIAGNOSIS OPPC	3348	The 16th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3230	2ND DIAG POA CODE IS MIS/INVALID	3409	1st Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3231	3RD DIAG POA CODE IS MIS/INVALID	3410	2nd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3232	4TH DIAG POA CODE IS MIS/INVALID	3411	3rd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3233	5TH DIAG POA CODE IS MIS/INVALID	3412	4th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

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

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

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3250	22ND DIAG POA CODE IS MIS/INVALID	3429	21st Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3251	23RD DIAG POA CODE IS MIS/INVALID	3430	22nd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3252	24TH DIAG POA CODE IS MIS/INVALID	3431	23rd Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
3253	25TH DIAG POA CODE IS MIS/INVALID	3432	24th Other Diagnosis POA is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3337	NON-COVERED PROC DUE TO CMS TERMINATION	247	Procedure code has been terminated by CMS, AMA or ADA for the Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
3338	ANESTHESIA RELATED PROCEDURE CODE NOT ON FILE	820	Anesthesia related procedure code billed is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
3340	SERVICE NOT COVERED BY NV MEDICAID	3340	Service not covered by NV Medicaid.	204	This service/equipment/drug is not covered under the patients current benefit plan		
3344	PERCENT OF BILL RATE NOT FOUND	132	Percentage of Bill rate not found. Claim could not be processed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
3347	NO PAYABLE ACCOMMODATION CODE	609	No payable accommodation code on claim.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3349	ANCILLARY NOT PAYABLE FOR DENIED OBSERVATION CODE	3349	Ancillary Not Payable for Denied Observation Code.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N161	This drug/service/supply is covered only when the associated service is covered.
3351	BILL NURSING HOME FOR THIS SERVICE	1296	Bill Nursing Home for this service.	109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
3352	SPC FOSTER CARE - ELIGIBILITY FORM 365 DAYS	3352	ELIGIBILITY CHECKLIST NOT COMPLETE OR MISSING, PLEASE CONTACT THE CARE COORDINATOR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
3353	SPECIALIZED FOSTER CARE CHECKLIST PT86	3352	ELIGIBILITY CHECKLIST NOT COMPLETE OR MISSING, PLEASE CONTACT THE CARE COORDINATOR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
3358	ALLOWED AMOUNT EXCEEDS THRESHOLD	509	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.	273	Coverage/program guidelines were exceeded.		
3363	NO PROCEDURE REIMBURSEMENT RULE FOR CLAIM REGION	1001	Procedure is not payable for this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3364	NO REVENUE REIMBURSEMENT RULE FOR CLAIM REGION	1005	Revenue code is not payable for this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3365	MCO PAID DATE IS INVALID	1644	MCO Paid Date is Invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N245	Incomplete/invalid plan information for other insurance.
3382	ABORTION CERTIFICATE REQUIRED - DTL	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3382	ABORTION CERTIFICATE REQUIRED - DTL	340	Consent Form must be signed and dated by recipient	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3382	ABORTION CERTIFICATE REQUIRED - DTL	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3382	ABORTION CERTIFICATE REQUIRED - DTL	346	Life of the mother is not indicated as being endangered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3382	ABORTION CERTIFICATE REQUIRED - DTL	347	Date of the recipient signature and the date of the person obtaining consent must be the same.	198	Precertification/notification/authorization/pre-treatment exceeded.	N351	Service date outside of the approved treatment plan service dates.

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

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3383	STERILIZATION FORM REQUIRED - HDR	3383	Sterilization Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3384	STERILIZATION FORM REQUIRED - DTL	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3384	STERILIZATION FORM REQUIRED - DTL	329	Physician on Recipient Statement does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3384	STERILIZATION FORM REQUIRED - DTL	334	RECIPIENT BELOW MIN AGE FOR CONSENT SIGNATURE	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3384	STERILIZATION FORM REQUIRED - DTL	335	Sterilization Done Outside Consent Time Limits	198	Precertification/notification/authorization/pre-treatment exceeded.	N351	Service date outside of the approved treatment plan service dates.
3384	STERILIZATION FORM REQUIRED - DTL	336	Statement of Person Obtaining Consent Not Completed	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3384	STERILIZATION FORM REQUIRED - DTL	338	Please Complete All Portions of the Federal Consent Form and Resubmit	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3384	STERILIZATION FORM REQUIRED - DTL	339	Interpreter's Statement Not Filled in Completely	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3384	STERILIZATION FORM REQUIRED - DTL	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3384	STERILIZATION FORM REQUIRED - DTL	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3384	STERILIZATION FORM REQUIRED - DTL	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3384	STERILIZATION FORM REQUIRED - DTL	350	The date of the interpreter's signature does not correspond to the date the recipient signed the form.	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3384	STERILIZATION FORM REQUIRED - DTL	383	Length of Stay Cut Back by Date of Sterilization; No Consent Form on File	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N3	Missing consent form.
3384	STERILIZATION FORM REQUIRED - DTL	3383	Sterilization Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3385	HYSTERECTOMY FORM REQUIRED - HDR	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3385	HYSTERECTOMY FORM REQUIRED - HDR	334	RECIPIENT BELOW MIN AGE FOR CONSENT SIGNATURE	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3385	HYSTERECTOMY FORM REQUIRED - HDR	338	Please Complete All Portions of the Federal Consent Form and Resubmit	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3385	HYSTERECTOMY FORM REQUIRED - HDR	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3385	HYSTERECTOMY FORM REQUIRED - HDR	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3385	HYSTERECTOMY FORM REQUIRED - HDR	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3385	HYSTERECTOMY FORM REQUIRED - HDR	3385	Hysterectomy Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3386	HYSTERECTOMY FORM REQUIRED - DTL	37	Claim Denied. Acknowledgement /Consent Form Is Missing, Incomplete, or Contains Invalid Information	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3386	HYSTERECTOMY FORM REQUIRED - DTL	334	RECIPIENT BELOW MIN AGE FOR CONSENT SIGNATURE	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.
3386	HYSTERECTOMY FORM REQUIRED - DTL	338	Please Complete All Portions of the Federal Consent Form and Resubmit	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3386	HYSTERECTOMY FORM REQUIRED - DTL	343	Surgery Date on Payment Request Not Same as Consent Form	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.
3386	HYSTERECTOMY FORM REQUIRED - DTL	348	Recipient on Consent Form does not correspond to Recipient on Claim.	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.
3386	HYSTERECTOMY FORM REQUIRED - DTL	349	Physician on Consent Form does not correspond to Physician on Claim	250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the information sent on the claim.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3386	HYSTERECTOMY FORM REQUIRED - DTL	3385	Hysterectomy Form Required	251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N705	Incomplete/invalid documentation.
3400	MEDICAID CANNOT PAY FOR VACCINES	3400	MEDICAID CANNOT PAY FOR VACCINES AVAILABLE THROUGH VFC	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M41	We do not pay for this as the patient has no legal obligation to pay for this.
3415	NET TIME REQUIRED - SCHEDULED APPOINTMENT TIME	2402	NET Time Required - Scheduled Appointment Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
3416	NET TIME REQUIRED - ACTUAL DROP-OFF TIME	2403	NET Time Required - Actual Drop-off Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3417	NET TIME REQUIRED - SCHEDULED PICK-UP TIME	2404	NET Time Required - Scheduled Pick-up Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
3418	NET TIME REQUIRED - ACTUAL PICK-UP TIME	2405	NET Time Required - Actual Pick-up Time	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
3709	ENCOUNTER TCN IS MISSING OR INVALID	2406	Encounter TCN is missing or invalid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
3710	DUPLICATE ENCOUNTER TCN SUBMITTED	2407	Duplicate Encounter TCN submitted.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3711	ENCOUNTER CLAIM STATUS NOT PRESENT	2408	Encounter Claim Status is not Present.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.
3712	ENCOUNTER PAID AMOUNT < 0	2409	Duplicate Encounter TCN submitted.	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
3714	ENCOUNTER LINE PAID AMOUNT = 0	2410	Encounter Line Paid Amount is zero.	23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)		
3715	ENCOUNTER LINE QUANTITY = 0 AND PAID AMOUNT > 0	2411	Encounter Line Quantity is zero and the Paid Amount is greater than zero.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.
3718	CMO RECEIPT DATE NOT VALID	2412	CMO Receipt Date is not valid.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3719	MEDICARE CROSSOVER IDENTIFIED CLAIM	2413	Medicare Crossover Identified Claim	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3723	ENCOUNTER TRIP NUMBER IS MISSING	2413	Medicare Crossover Identified Claim	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3724	ENCOUNTER INVALID NET PROCEDURE CODE	2416	Encounter Invalid NET Procedure Code.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3728	NO PROC REIMB RULE FOR RECIP AGE	1552	This procedure is age restricted. Member's age does not fall within the approved age range.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
3733	PROCEDURE RSTCN FOR REV CVG RULE	393	The revenue code and procedure code are in conflict. Please verify whether a HCPC can be used with this revenue code and ensure the procedure code is appropriate for the revenue code used.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
3738	NO PROC REIMB RULE FOR BENEFIT PLAN	1544	The service is not reimbursable for the member's benefit plan.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3739	NO REV REIMB RULE FOR BENEFIT PLAN	1544	The service is not reimbursable for the member's benefit plan.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3740	PRIMARY HDR DIAG RSTCN FOR REV COVERAGE RULE	1568	Revenue code is not covered with this principal header diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
3741	FAMILY PLANNING RSTCN FOR REV CVG RULE	1542	The revenue code has Family Planning restrictions.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3742	FAMILY PLANNING RSTCN FOR PROC CVG RULE	1541	The procedure code has Family Planning restrictions.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
3744	NO BENEFIT COVERAGE RULE FOR CLAIM REGION	1006	Service is not covered for claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3748	NO PROC REIMB RULE FOR CLAIM TYPE	1023	Procedure is not payable for this claim type.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3749	NO REV CODE REIMB RULE FOR CLAIM TYPE	1010	Revenue code is not payable for this claim type.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3768	NO PROC REIMB RULE FOR PROVIDER CONTRACT	1013	Claim is not payable for the billed procedure.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3803	GEO PROV RENDERING PROC REIMB RULE	1104	Service is not payable to rendering provider in this location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
3848	NO PROC REIMB RULE FOR GEO PROVBILL	1114	Service is not payable to billing provider in this location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
3853	BILLING PRO LOCATION STATUS - PROC CVG RULE	1560	Procedure is not covered with this billing provider location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3855	BILLING PROV LOCATION STATUS - REV CVG RULE	1561	Revenue code is not covered with this billing provider location.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
3858	NO PROC REIMB RULE FOR GEO LOC RECIP	1115	Service is not payable to recipient in this location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3861	BILLING PROV LOCATION STATUS - PROC BILL RULE	1559	Billing Provider is not authorized to provide service from billing location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3863	BILLING PROV LOCATION STATUS - REV BILL RULE	1559	Billing Provider is not authorized to provide service from billing location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3867	BILLING PROV LOCATION STATUS - REIMB REV RULE	1559	Billing Provider is not authorized to provide service from billing location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3869	PERFORMING PROV LOCATION STATUS - PROC CVG RULE	1562	Revenue code is not covered with this rendering provider location.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.
3871	PERFORMING PROV LOCATION STATUS - PROC BILL RULE	1558	Servicing Provider is not authorized to provide service from service location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3872	PERFORMING PROV LOCATION STATUS REV BILL RULE	1558	Servicing Provider is not authorized to provide service from service location.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3877	NO REV CODE REIMB RULE FOR LOCKIN PLAN	1563	The service is not payable under the client's lock-in plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3878	NO PROC BILLING RULE FOR LOCKIN PLAN	1563	The service is not payable under the client's lock-in plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
3888	NO REIMBURSEMENT RULE FOR PLACE OF SERVICE	1557	Service is not payable for the billed place of service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N428	Not covered when performed in this place of service.
3896	PROCEDURE RSTCN FOR REV BILL RULE	1116	The Revenue Code requires an appropriate corresponding Procedure Code.	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.
3897	QUANTITY RESTRICTION ON REV BILLING RULE	1273	Quantity Billed is invalid for the Revenue Code.	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N587	Policy benefits have been exhausted.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3898	REVENUE CODE RESTRICTION ON ICD BILLING RULE	1550	ICD procedure was not billed with the appropriate revenue codes.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3904	BENEFIT PLAN GROUP RSTCN ON PROC BILLING RULE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
3905	BENEFIT PLAN GROUP RSTCN ON REV BILLING RULE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
3930	NO PROC REIMB RULE FOR BILLING PT/PS	182	Billing Provider is not certified to bill service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3932	NO PROC REIMB RULE FOR RENDERING PT/PS	1132	Rendering Provider Type and/or Specialty is not allowable for the service billed.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N198	Rendering provider must be affiliated with the pay-to provider.
3940	NO REV CODE REIMB RULE FOR BILLING PT/PS	182	Billing Provider is not certified to bill service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
3958	NO REIMB RULE FOR PROC	1178	Service is not reimbursable for Date(s) of Service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N43	Bed hold or leave days exceeded.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
3959	NO REIMB RULE FOR REV CODE	1178	Service is not reimbursable for Date(s) of Service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N43	Bed hold or leave days exceeded.
3960	MODIFIER RSTCN ON REIMB REV RULE	1579	Service is not payable for this modifier.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
3968	NO REV CODE REIMB RULE FOR TOB	229	The Type of Bill is not allowed for the service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
3969	NO REV CODE REIMB RULE FOR PROVIDER CONTRACT	1580	Revenue code not covered under provider?s contract.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4004	NDC NOT ON FILE	1354	National Drug Code (NDC) is not on file.	204	This service/equipment/drug is not covered under the patients current benefit plan		
4006	AMOUNT PAID HIGH VARIANCE	509	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.	273	Coverage/program guidelines were exceeded.		
4009	ALLOWED AMT MORE THAN BILLED AMOUNT VARIANCE	509	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.	273	Coverage/program guidelines were exceeded.		

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4030	AGE RESTRICTION ON DIAG CVG RULE	1119	One or more Diagnosis Codes has an age restriction.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4031	GENDER RESTRICTION FOR DIAG BILLING RULE	801	One or more diagnosis codes are not applicable to the client's gender.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4032	PROCEDURE CODE NOT ON FILE	3180	The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
4033	3RD DIAGNOSIS NOT COVERED	413	2nd Other Diagnosis (Institutional), 3rd Diagnosis Code (Professional/Dental) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4034	AGE RESTRICTION ON PROC CVG RULE	1121	Member does not meet the age restriction for this Procedure Code.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4036	PLACE OF SERVICE RESTRICTION ON PROC CVG RULE	1197	The Procedure Code has Place of Service restrictions.	5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4038	4TH DIAGNOSIS NOT COVERED	414	3rd Other Diagnosis (Institutional), 4th Diagnosis Code (Professional/Dental) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4039	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS	61	Diagnosis cannot be used as a principal diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.
4040	2ND DIAGNOSIS CODE NOT ON FILE	3720	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4041	3RD DIAGNOSIS CODE NOT ON FILE	3730	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4042	4TH DIAGNOSIS CODE NOT ON FILE	3740	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis Code (Professional/Dental) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4043	5TH DIAGNOSIS CODE NOT ON FILE	3930	The 4th Other Diagnosis code (Institutional), 5th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4044	12TH DIAGNOSIS CODE NOT ON FILE	7319	The 11th Other Diagnosis Code (Institutional), 12th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4045	11TH DIAGNOSIS CODE NOT ON FILE	7313	The 10th Other Diagnosis Code (Institutional), 11th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4046	PROCEDURE CODE NOT EFFECTIVE FOR DOS	3181	The procedure code is invalid for date of service. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
4047	6TH DIAGNOSIS CODE NOT ON FILE	5260	The 5th Other Diagnosis code (Institutional), 6th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4048	7TH DIAGNOSIS CODE NOT ON FILE	5270	The 6th Other Diagnosis code (Institutional), 7th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4049	8TH DIAGNOSIS CODE NOT ON FILE	5280	The 7th Other Diagnosis code (Institutional), 8th Diagnosis Code (Professional) is invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4050	9TH DIAGNOSIS CODE NOT ON FILE	5290	The 8th Other Diagnosis code (Institutional), 9th Diagnosis Code (Professional) is invalid. Correct the diagnosis.	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4051	10TH DIAGNOSIS CODE NOT ON FILE	7307	The 9th Other Diagnosis Code (Institutional), 10th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4052	ADMITTING DIAGNOSIS CODE NOT ON FILE	1264	Admit Diagnosis is not on file.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.
4053	PRINCIPAL ICD PROCEDURE CODE NOT ON FILE	870	The Principal ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4053	PRINCIPAL ICD PROCEDURE CODE NOT ON FILE	870	The Principal ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4054	1ST OTHER ICD PROCEDURE CODE NOT ON FILE	871	The 1st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4055	2ND OTHER ICD PROCEDURE CODE NOT ON FILE	872	The 2nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
4056	3RD OTHER ICD PROCEDURE CODE NOT ON FILE	873	The 3rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4057	4TH OTHER ICD PROCEDURE CODE NOT ON FILE	874	The 4th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4058	5TH OTHER ICD PROCEDURE CODE NOT ON FILE	875	The 5th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4059	REVENUE CODE NOT ON FILE	3752	The revenue code is not on file. Refer to the current revenue code table for valid codes.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
4061	13TH DIAGNOSIS CODE NOT ON FILE	7325	The 12th Other Diagnosis Code (Institutional) is invalid. Correct the diagnosis code.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4063	5TH DIAGNOSIS NOT COVERED	415	4th Other Diagnosis (Institutional), 5th Diagnosis Code (Professional) is not covered.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4064	6TH DIAGNOSIS NOT COVERED	416	5th Other Diagnosis (Institutional), 6th Diagnosis Code (Professional) is not covered.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4065	7TH DIAGNOSIS NOT COVERED	417	6th Other Diagnosis (Institutional), 7th Diagnosis Code (Professional) is not covered.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4067	1ST OTHER ICD PROCEDURE NOT COVERED	561	The 1st Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4068	8TH DIAGNOSIS NOT COVERED	418	7th Other Diagnosis (Institutional), 8th Diagnosis Code (Professional) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4069	9TH DIAGNOSIS NOT COVERED	477	Services with the 8th Other Diagnosis code are not a benefit.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4070	MODIFIER RESTRICTION FOR PROC REIMBURSEMENT RULE	1512	The Procedure Code/Modifier combination is not payable for the Date of Service.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4071	10TH DIAGNOSIS NOT COVERED	420	9th Other Diagnosis code (Institutional), 10th Diagnosis Code (Professional) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4072	11TH DIAGNOSIS NOT COVERED	421	10th Other Diagnosis code (Institutional), 11th Diagnosis Code (Professional) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4073	12TH DIAGNOSIS NOT COVERED	422	11th Other Diagnosis code (Institutional), 12th Diagnosis Code (Professional) is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4074	13TH DIAGNOSIS NOT COVERED	423	12th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4075	14TH DIAGNOSIS NOT COVERED	424	13th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4076	15TH DIAGNOSIS NOT COVERED	425	14th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4077	REVENUE CODE NOT EFFECTIVE FOR DOS	1187	The Revenue Code is not payable for the Date(s) of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
4078	16TH DIAGNOSIS NOT COVERED	426	15th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4079	17TH DIAGNOSIS NOT COVERED	427	16th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4080	18TH DIAGNOSIS NOT COVERED	428	17th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4082	19TH DIAGNOSIS NOT COVERED	429	18th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4083	20TH DIAGNOSIS NOT COVERED	430	19th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4084	ALLOWED AMT LESS THAN BILLED AMOUNT VARIANCE	507	ALLOWED AMOUNT LESS THAN BILLED AMOUNT VARIANCE.	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.		
4086	21ST DIAGNOSIS NOT COVERED	431	20th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4087	22ND DIAGNOSIS NOT COVERED	432	21st Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4089	MISSING/INVALID HCPCS SURGICAL CDE/SURGERY REV	2860	ASC Rate cannot be determined - Missing or Invalid HCPCS Surgical Code/Revenue Code	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4090	23RD DIAGNOSIS NOT COVERED	433	22nd Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4091	24TH DIAGNOSIS NOT COVERED	434	23rd Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4092	25TH DIAGNOSIS NOT COVERED	435	24th Other Diagnosis is not covered.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4093	2ND DIAG GENDER CONFLICT	3242	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis Code (Professional/Dental) is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4094	3RD DIAG GENDER CONFLICT	3243	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional/Dental) is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

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

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4129	21ST DIAG GENDER CONFLICT	7376	The 20th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4130	PAYER HIERARCHY NOT FOUND	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4131	NO BENEFIT PLANS ASSOCIATED TO PAYER	0	This claim/service is pending for program review.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4136	22ND DIAG GENDER CONFLICT	7382	The 21st Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4137	23RD DIAG GENDER CONFLICT	7388	The 22nd Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4139	24TH DIAG GENDER CONFLICT	7394	The 23rd Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4140	25TH DIAG GENDER CONFLICT	7400	The 24th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4141	PERF/FACILITY PT/PS RESTRICTION ON PROC CVG RULE	1388	The Procedure Code is not reimbursable for the Rendering Provider Type and/or Specialty.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N808	Not covered for this provider type / provider specialty.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4142	ADMITTING DIAG GENDER CONFLICT	1100	The admitting diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4143	BILLING PT/PS RESTRICTION ON REV CODE CVG RULE	182	Billing Provider is not certified to bill service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4144	PERF/FACILITY PT/PS RESTRICTION ON DIAG BILL RULE	558	The service requested is not allowable for the Diagnosis indicated.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4145	2ND DIAG AGE CONFLICT	3232	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid for client's age. Correct the diagnosis code/client's birth	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4146	3RD DIAG AGE CONFLICT	3233	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid for client's age. Correct the diagnosis code/client's birth	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4147	4TH DIAG AGE CONFLICT	3234	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis code (Professional/Dental) is invalid for client's age. Correct the diagnosis code/client's birth	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4148	5TH DIAG AGE CONFLICT	3235	The 4th Other Diagnosis code (Institutional), 5th Diagnosis code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4149	BILLING PT/PS RESTRICTION ON PROC BILLING RULE	182	Billing Provider is not certified to bill service.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4150	PERF/FACILITY PT/PS RESTRICTION PROC BILLING RULE	1280	Rendering Provider is not certified to perform procedure billed.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4151	BILLING PT/PS RESTRICTION ON REV CODE BILLING RULE	3020	Billing Provider Type and/or Specialty is not allowable for the revenue code billed.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4152	6TH DIAG AGE CONFLICT	3236	The 5th Other Diagnosis (Institutional), 6th Diagnosis code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4154	7TH DIAG AGE CONFLICT	3237	The 6th Other Diagnosis (Institutional) 7th Diagnosis Code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4155	8TH DIAG AGE CONFLICT	3238	The 7th Other Diagnosis (Institutional), 8th Diagnosis Code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4156	9TH DIAG AGE CONFLICT	3239	The 8th Other Diagnosis (Institutional), 9th Diagnosis code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4157	10TH DIAG AGE CONFLICT	3268	The 9th Other Diagnosis (Institutional), 10th Diagnosis code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4158	11TH DIAG AGE CONFLICT	7315	The 10th Other Diagnosis (Institutional), 11th Diagnosis Code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4159	12TH DIAG AGE CONFLICT	7321	The 11th Other Diagnosis (Institutional), 12th Diagnosis Code (Professional) is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4160	13TH DIAG AGE CONFLICT	7327	The 12th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4161	14TH DIAG AGE CONFLICT	7333	The 13th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4162	15TH DIAG AGE CONFLICT	7339	The 14th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4163	QUANTITY RESTRICTION ON PROC BILLING RULE	1275	Quantity Billed is restricted for this Procedure Code.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
4165	16TH DIAG AGE CONFLICT	7345	The 15th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4166	17TH DIAG AGE CONFLICT	7351	The 16th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4167	18TH DIAG AGE CONFLICT	7357	The 17th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4168	19TH DIAG AGE CONFLICT	7363	The 18th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4173	20TH DIAG AGE CONFLICT	7369	The 19th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4177	21ST DIAG AGE CONFLICT	7375	The 20th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4179	22ND DIAG AGE CONFLICT	7381	The 21st Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4180	MUE PROFESSIONAL	1690	Quantity indicated for this service exceeds the maximum quantity limit established by the National Correct Coding Initiative.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
4181	MUE DME	1690	Quantity indicated for this service exceeds the maximum quantity limit established by the National Correct Coding Initiative.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
4182	MUE OUTPATIENT	1690	Quantity indicated for this service exceeds the maximum quantity limit established by the National Correct Coding Initiative.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
4187	23RD DIAG AGE CONFLICT	7387	The 22nd Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4188	24TH DIAG AGE CONFLICT	7393	The 23rd Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4189	25TH DIAG AGE CONFLICT	7399	The 24th Other Diagnosis is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4190	ADMITTING DIAG AGE CONFLICT	3230	The admitting diagnosis code is invalid for client's age. Correct the diagnosis code/client's birth date.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4191	PRINCIPAL DIAG AGE CONFLICT	3231	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid for client's age. Correct the diagnosis code/client's birth	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4192	PRINCIPAL DIAG GENDER CONFLICT	3241	The Principal Diagnosis code (Institutional), 1st Diagnosis Code (Professional/Dental) is invalid for client's sex.Correct the diagnosis code/sex indicator.	10	The diagnosis is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N517	Resubmit a new claim with the requested information.
4193	Diagnosis codes P00-P96 diag age conflict	4193	Diagnosis code age restriction does not match recipient.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4194	DIAGNOSIS CODES P00-P96 DIAG AGE CONFLICT - DENY	4193	Diagnosis code age restriction does not match recipient.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4200	CLAIM PRICED AT ZERO	42	Claim Priced at zero.	204	This service/equipment/drug is not covered under the patients current benefit plan		
4208	CLIA LICENSE NUMBER INVALID	793	PROVIDER NOT CLIA CERTIFIED TO PERFORM LAB PROCEDURE.	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA120	Missing/incomplete/invalid CLIA certification number.
4209	NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMB	3530	There is no rate on file for procedure/modifier combination for the date of service. Charges cannot be processed.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4211	TOOTH NUMBER/PROCEDURE CODE COMBINATION INVALID	364	Procedure Code/Tooth Number Conflict - Tooth number on claim is not valid with the submitted procedure code. Please correct and resubmit your claim.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N39	Procedure code is not compatible with tooth number/letter.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4219	MEDICAL REVIEW FOR REV CODE CVG RULE - DENY	325	Non-Emergent Services not Authorized for Non-Citizens	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4220	REVIEW C-SECTION FOR MEDICAL NECESSITY - DENY	4222	REVIEW C-SECTION FOR MEDICAL NECESSITY	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N661	Documentation does not support that the services rendered were medically necessary.
4221	MEDICAL REVIEW FOR PROC CVG RULE - DENY	325	Non-Emergent Services not Authorized for Non-Citizens	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4222	REVIEW C-SECTION FOR MEDICAL NECESSITY	4222	REVIEW C-SECTION FOR MEDICAL NECESSITY	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N661	Documentation does not support that the services rendered were medically necessary.
4223	MEDICAL REVIEW FOR PROC CVG RULE	325	Non-Emergent Services not Authorized for Non-Citizens	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4224	NO INPATIENT PA FOR NON-EMERGENT NON-CITIZEN SVCS	325	Non-Emergent Services not Authorized for Non-Citizens	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4227	NO CVG RULE FOR REVENUE CODE	1378	The Revenue Code is not payable for the Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
4238	SERVICE NOT VALID FOR LAST 7 DAYS OF HOSPICE	600	SERVICE NOT VALID FOR LAST 7 DAYS OF HOSPICE	B9	Patient is enrolled in a Hospice.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4239	RECIPIENT NOT ENROLLED WITH LOC/HOSPICE	4239	RECIPIENT NOT ENROLLED WITH LOC/HOSPICE.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4240	1ST DIAGNOSIS CODE NOT ON FILE	3130	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
4240	1ST DIAGNOSIS CODE NOT ON FILE	3130	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.
4241	UNABLE TO DETERMINE LEVEL OF CARE	404	The member has no Level of Care (LOC) authorization on file or the LOC on file does not match the LOC on the claim.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N188	The approved level of care does not match the procedure code submitted.
4244	NO CVG RULE FOR DIAGNOSIS	1190	One or more Diagnosis Code(s) is not payable for the Date of Service.	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4245	FOURTH MODIFIER INVALID	1514	The fourth modifier code is invalid for date of service.	182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4247	PRINCIPAL ICD PROCEDURE NOT COVERED	2300	The Principal ICD Procedure is not a Covered Benefit.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
4248	2ND OTHER ICD PROCEDURE NOT COVERED	571	The 2nd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4249	3RD OTHER ICD PROCEDURE NOT COVERED	522	The 3rd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4250	4TH OTHER ICD PROCEDURE NOT COVERED	527	The 4th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

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

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

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

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4274	22ND OTHER ICD PROCEDURE NOT COVERED	2322	The 22nd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4275	23RD OTHER ICD PROCEDURE NOT COVERED	2323	The 23rd Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4276	24TH OTHER ICD PROCEDURE NOT COVERED	2324	The 24th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4277	7TH OTHER ICD PROCEDURE CODE NOT ON FILE	877	The 7th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4278	8TH OTHER ICD PROCEDURE CODE NOT ON FILE	878	The 8th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4279	9TH OTHER ICD PROCEDURE CODE NOT ON FILE	879	The 9th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4280	10TH OTHER ICD PROCEDURE CODE NOT ON FILE	880	The 10th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4281	11TH OTHER ICD PROCEDURE CODE NOT ON FILE	881	The 11th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4282	12TH OTHER ICD PROCEDURE CODE NOT ON FILE	882	The 12th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4283	13TH OTHER ICD PROCEDURE CODE NOT ON FILE	883	The 13th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4284	14TH OTHER ICD PROCEDURE CODE NOT ON FILE	884	The 14th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4285	15TH OTHER ICD PROCEDURE CODE NOT ON FILE	885	The 15th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4286	16TH OTHER ICD PROCEDURE CODE NOT ON FILE	886	The 16th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4287	17TH OTHER ICD PROCEDURE CODE NOT ON FILE	887	The 17th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4288	18TH OTHER ICD PROCEDURE CODE NOT ON FILE	888	The 18th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4289	19TH OTHER ICD PROCEDURE CODE NOT ON FILE	889	The 19th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4290	20TH OTHER ICD PROCEDURE CODE NOT ON FILE	890	The 20th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4291	21ST OTHER ICD PROCEDURE CODE NOT ON FILE	891	The 21st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4292	22ND OTHER ICD PROCEDURE CODE NOT ON FILE	892	The 22nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4293	23RD OTHER ICD PROCEDURE CODE NOT ON FILE	893	The 23rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4294	24TH OTHER ICD PROCEDURE CODE NOT ON FILE	894	The 24th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4295	13TH OTHER ICD PROCEDURE NOT COVERED	2313	The 13th Other ICD Procedure is not a Covered Benefit.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).
4311	PRIMARY HDR DIAG RSTCN FOR PROC BILLING RULE	1519	The First Diagnosis Code is invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4312	PRIMARY DTL DIAG RSTCN FOR PROC BILLING RULE	1519	The First Diagnosis Code is invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4313	SECONDARY DTL DIAG RSTCN FOR PROC BILLING RULE	1517	One or more of the Secondary Diagnosis Code(s) are invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4314	CLAIM TYPE RESTRICTION ON DIAG CVG RULE	1554	The claim type and diagnosis code submitted are not payable.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.
4315	ANY HDR DIAG RSTCN FOR PROC BILLING RULE	80	PROCEDURE CODE NOT PAYABLE WITH DIAGNOSIS ENTERED	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4316	ANY DTL DIAG RSTCN FOR PROC BILLING RULE	80	PROCEDURE CODE NOT PAYABLE WITH DIAGNOSIS ENTERED	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4318	PRIMARY HDR DIAG RESTRICTION ON ICD BILLING RULE	1515	The Primary Diagnosis Code is invalid for the ICD Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4321	PRIMARY HDR DIAG RSTCN FOR REV CODE BILLING RULE	1516	The Primary Diagnosis Code is invalid for the Revenue Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4322	ANY HDR DIAG RSTCN FOR REV BILL RULE	1581	Diagnos(es) not allowable for the billed Revenue Code.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4342	15TH DIAGNOSIS CODE NOT ON FILE	7337	The 14th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4343	16TH DIAGNOSIS CODE NOT ON FILE	7343	The 15th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4344	17TH DIAGNOSIS CODE NOT ON FILE	7349	The 16th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4345	18TH DIAGNOSIS CODE NOT ON FILE	7355	The 17th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.
4346	19TH DIAGNOSIS CODE NOT ON FILE	7361	The 18th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4348	20TH DIAGNOSIS CODE NOT ON FILE	7367	The 19th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4349	21ST DIAGNOSIS CODE NOT ON FILE	7373	The 20th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4362	TYPE OF BILL RESTRICTION ON DIAG BILLING RULE	229	The Type of Bill is not allowed for the service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
4366	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID AM	3022	Both the Medicare allowed amount and Medicare paid amount and one or more of the following amounts: deductible, coinsurance and/or copayment, on all crossover claims. Claims will be denied if the Medicare payments are not indicated on the claim at the detail level.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
4367	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID AM	3022	Both the Medicare allowed amount and Medicare paid amount and one or more of the following amounts: deductible, coinsurance and/or copayment, on all crossover claims. Claims will be denied if the Medicare payments are not indicated on the claim at the detail level.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
4370	22ND DIAGNOSIS CODE NOT ON FILE	7379	The 21st Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4371	CLAIM TYPE RESTRICTION ON PROC CVG RULE	1379	The service are not covered for the client's benefit plan when billed on this claim type.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.
4372	SECONDARY HDR DIAG RSTCN FOR PROC BILLING RULE	1517	One or more of the Secondary Diagnosis Code(s) are invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4374	CLAIM TYPE RESTRICTION ON REV CODE CVG RULE	1379	The service are not covered for the client's benefit plan when billed on this claim type.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.
4379	23RD DIAGNOSIS CODE NOT ON FILE	7385	The 22nd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4380	24TH DIAGNOSIS CODE NOT ON FILE	7391	The 23rd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4381	25TH DIAGNOSIS CODE NOT ON FILE	7397	The 24th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code	146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.
4711	AGE RESTRICTION ON DIAG BILLING RULE	1518	Diagnosis Code is restricted by member age.	9	The diagnosis is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4712	AGE RESTRICTION ON REVENUE CODE BILLING RULE	4712	Revenue Code is restricted by member age.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4714	AGE RESTRICTION ON PROC BILLING RULE	184	Procedure Code is restricted by member age.	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
4724	ANY HDR DIAG RSTCN FOR ICD CVG RULE	1221	Diagnosis Restriction on ICD Coverage Rule	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4731	ANY DTL DIAG RSTCN FOR PROC CVG RULE	1377	The Procedure Code has Diagnosis restrictions.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4733	ANY HDR DIAG RSTCN FOR REV CVG RULE	407	None of the submitted diagnoses on the claim are covered for this revenue code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4741	PROC ON ANY DTL RESTRICTION ON PROCEDURE CVG RULE	1567	Procedure on any detail restriction on procedure coverage rule.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4742	PRIMARY HDR DIAG RSTCN FOR PROC CVG RULE	1519	The First Diagnosis Code is invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4743	SECONDARY DTL DIAG RSTCN FOR PROC CVG RULE	1517	One or more of the Secondary Diagnosis Code(s) are invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4744	SECONDARY HDR DIAG RSTCN FOR PROC CVG RULE	1520	The Secondary Diagnosis Code is inappropriate for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4745	ANY HDR DIAG RSTCN FOR PROC CVG RULE	406	None of the submitted diagnoses on the claim are covered for this procedure code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4746	FIRST DTL DIAG RSTRCN FOR PROC CVG RULE	1519	The First Diagnosis Code is invalid for the Procedure Code.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.
4747	PRIMARY HDR DIAG RESTRICTION ON REVENUE CVG RULE	1568	Revenue code is not covered with this principal header diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4748	CURR BENEFIT PLAN RSTCN ON PROC BILLING RULE	1544	The service is not reimbursable for the member's benefit plan.	204	This service/equipment/drug is not covered under the patients current benefit plan	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4749	1ST DTL DIAGNOSIS RESTRICTION ON PROC BILLING RULE	1239	The Procedure Code has Diagnosis restrictions.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4751	TYPE OF BILL RESTRICTION ON REV CODE BILLING RULE	229	The Type of Bill is not allowed for the service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA30	Missing/incomplete/invalid type of bill.
4752	TYPE OF BILL CTBF RESTRICTION ON DIAG BILLING RULE	1556	Type of Bill is not allowable for the Billed Diagnosis.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4753	TYPE OF BILL CTBF RESTRICTION ON PROC BILLING RULE	1592	CPT/HCPCS codes are not reimbursable on this type of bill.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4754	TYPE OF BILL RESTRICTION ON PROC BILLING RULE	1592	CPT/HCPCS codes are not reimbursable on this type of bill.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4755	TYPE OF BILL CTBF RSTCN ON REV CODE BILLING RULE	1548	TYPE OF BILL RESTRICTION ON PROC BILLING RULE CPT/HCPCS codes are not reimbursable on this type of bill.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.
4756	TYPE OF BILL CTBF RSTCN ON PROC REIMB RULE	1572	Procedure code is not reimbursable for this type of bill.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4757	TYPE OF BILL CTBF RSTCN ON REV CODE REIMB RULE	1378	The Revenue Code is not payable for the Date of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
4758	BILLING PT/PS RSTCN ON PROC COVERAGE RULE	1551	Billing Provider's PT/PS not allowed to bill the procedure under the Client's Benefit Plan.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N95	This provider type/provider specialty may not bill this service.
4759	PROV CONTRACT RSTCN ON PROC COVERAGE RULE	1574	BILLING PROVIDER TYPE/SPECIALTY RESTRICTION ON PROCEDURE COVERAGE RULE.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4761	CONTRACT RSTCN ON REV CODE CVG RULE	1580	Revenue code not covered under provider?s contract.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
4765	NO CVG RULE FOR SURGICAL PROCEDURE	1380	ICD Procedure Code not covered for the date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4768	MEDICAL REVIEW FOR SURGICAL PROCEDURE CVG RULE	1103	This surgical procedure requires medical review.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N35	Program integrity/utilization review decision.
4776	BILLING PT/PS RESTRICTION ON DIAG BILLING RULE	1555	BILLING PROVIDER TYPE/SPECIALTY NOT ALLOWABLE FOR BILLED DIAGNOSIS.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4777	CONDITION CODE RESTRICTION ON PROC BILLING RULE	931	Condition Code is missing/invalid or incorrect for the Procedure or Revenue Code submitted.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.
4780	REVENUE CODE RESTRICTION ON PROC BILLING RULE	1116	The Revenue Code requires an appropriate corresponding Procedure Code.	199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.
4790	EMERGENCY INDICATOR RSTCN ON PROC BILLING RULE	1727	Emergency Indicator Restriction on billed procedure.	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4791	EMERGENCY INDICATOR RSTCN ON PROC CVG RULE	1728	Emergency Indicator Restriction on covered procedure.	40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4811	MEDICAL REVIEW FOR PROC BILLING RULE	241	Benefit Determined Per Medical Review	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4812	MEDICAL REVIEW FOR DIAG BILLING RULE	241	Benefit Determined Per Medical Review	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4813	MEDICAL REVIEW FOR PROC BILLING RULE	241	Benefit Determined Per Medical Review	50	These are non-covered services because this is not deemed a medical necessity by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
4820	Aid Code Not Eligible for Procedure	4820	Recipient's aid code is not eligible for procedure code	204	This service/equipment/drug is not covered under the patients current benefit plan		
4821	PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE	1279	Procedure not payable for Place of Service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid/inappropriate place of service.
4861	CLAIM REGION RESTRICTION ON DIAGNOSIS CVG RULE	1564	Diagnosis is not covered with this claim region	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4862	CLAIM REGION RESTRICTION ON ICD PROC CVG RULE	1566	ICD procedure is not covered with this claim region.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4872	CLAIM TYPE RESTRICTION ON DIAG BILLING RULE	1545	The diagnosis code is not reimbursable for the claim type submitted.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.
4874	CLAIM TYPE RESTRICTION ON REV CODE BILLING RULE	770	The Revenue Code Cannot Be Billed on this Claim Type.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.
4876	CLAIM TYPE RESTRICTION ON ICD BILLING RULE	1565	ICD procedure is not covered with this claim type.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4901	BILLING PROV GEO LOC RSTCN ON REV REIMB RULE	4901	Billing Provider Geographic Location Restriction on Revenue Reimbursement Rule.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
4902	CLIENT GEO LOC RSTCN ON REV REIMB RULE	4902	Client Geographic Location Restriction on Revenue Reimbursement Rule.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
4903	PROC DOES NOT MATCH PROC GROUP ON PROC CVG RULE	4903	Procedure is not covered. (Does not match Procedure Group on Procedure Coverage Rule)	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.
4944	GENDER RESTRICTION FOR ICD BILLING RULE	1281	ICD Procedure Code billed is not appropriate for member's gender.	7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4963	GENDER RESTRICTION FOR PROC BILLING RULE	185	Procedure Code billed is not appropriate for member's gender.	7	The procedure/revenue code is inconsistent with the patients gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
4975	BENEFIT PLAN RESTRICTION FOR REV BILLING RULE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
4985	CURR BENEFIT PLAN RSTCN ON REV CODE BILLING RULE	698	Service is not billable with client's Benefit Plan.	204	This service/equipment/drug is not covered under the patients current benefit plan		
5000	EXACT DUPLICATE: INPATIENT TO INPATIENT	5000	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5001	POSSIBLE DUPLICATE: INPATIENT TO INPATIENT	5001	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5002	POSS CONFLICT: PT44 (SWING BED ACUTE HOSP) VS OTHE	5002	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5003	POSS CONFLICT: PT13 (PSYCH HOSP INPAT) VS OTHERS	5003	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5003	POSS CONFLICT: PT13 (PSYCH HOSP INPAT) VS OTHERS	8223	Services included in Inpatient Stay	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M2	Not paid separately when the patient is an inpatient.
5004	POSS CONFLICT: PT63 (RTC) VS OTHERS	5004	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5004	POSS CONFLICT: PT63 (RTC) VS OTHERS	8223	Services included in Inpatient Stay	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M2	Not paid separately when the patient is an inpatient.
5005	POSS CON: PT56 MED RHB/LTAC SPC HOSP VS OTHR FCLTY	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5006	POSS DUPE: INPAT TO OUTPA AND OUTPA TO INPAT	5006	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5007	POSSIBLE DUPLICATE: INPATIENT VS MEDICARE	5007	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5008	EXACT DUPE: INPAT CROSSOVER TO INPAT CROSSOVER	5008	INPATIENT CROSSOVER-EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5009	POSS DUPE: INPAT CROSSOVER TO INPAT CROSSOVER	5009	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5010	EXACT DUPLICATE: OUTPATIENT TO OUTPATIENT	5010	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5011	POSSIBLE DUPLICATE: OUTPATIENT TO OUTPATIENT	5011	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5012	POSSIBLE DUPLICATE: OUTPATIENT VS MEDICARE	5012	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5013	POSS DUPE: PT 10 VS PT 46 AND PT 46 VS PT 10	5013	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5015	POSS CON:OUTPA TO OUTP XO AND OUTP XO TO OUTP-MODI	5015	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5016	EXACT DUPLICATE: HOME HEALTH TO HOME HEALTH	5016	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5017	POSSIBLE DUPLICATE: HOME HEALTH TO HOME HEALTH	5017	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5018	EXACT DUPE: NURSING FACILITY TO NURSING FACILITY	5018	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5019	POSS DUPE: NURSING FACILITY TO NURSING FACILITY	5019	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5021	EXACT DUPLICATE: ICIID FACILITY TO ICIID FACILITY	5021	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5022	POSS DUPE: ICIID FACILITY TO ICIID FACILITY	5022	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5023	POSS DUPE: INPATIENT VS ADULT DAY HEALTH CARE	5023	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5024	INPATIENT/OUTPATIENT CONFLICT	5024	INPATIENT/OUTPATIENT SERVICES DATE CONFLICT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5028	EXACT DUPLICATE - OUTPA XOVER TO OUTPA XOVER	5028	EXACT DUPLICATE - OUTPATIENT XOVER TO OUTPATIENT XOVER	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5033	EXACT DUPLICATE: PCS TO PCS	5033	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5034	POSSIBLE DUPLICATE: PCS TO PCS	5034	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5035	EXACT DUPLICATE: PRACTITIONER TO PRACTITIONER	5035	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5036	POSSIBLE DUPLICATE: PRACTITIONER TO PRACTITIONER	5036	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5037	POSS DUPE: PRACT TO PRACT - RADIOLOGY	5037	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5038	POSS DUPE: PT20 PHYS MD OSTEOPATH DO VS OTHERS	5038	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5039	POSSIBLE DUPLICATE: ASC VS OTHERS	5039	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5040	POSSIBLE DUPLICATE: PRACTITIONER VS MEDICARE	5040	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5041	POSS CON: PT48 HCBS VS INP/LTC	5041	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5042	POSS CON: PT38 WVR FOR IID AND RELATED COND VS OTH	5042	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5043	POSS CON: PT14 BEHOP TREATMENT VS OTHERS	5043	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5044	POSS CON: PROVIDER TYPE 54 (TCM) VS OTHERS	5044	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5045	POSS CON: PT26 PSYCHOLOGIST VS OTHERS	5045	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5046	EXACT DUPLICATE: LAB TO LAB	5046	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5047	POSSIBLE DUPLICATE: LAB TO LAB	5047	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5048	EXACT DUPLICATE: TRANSPORTATION TO TRANSPORTATION	5048	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5049	POSS DUPE: TRANSPORTATION TO TRANSPORTATION	5049	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5050	POSS DUPE: INP vs. Nursing Facility vs. ICI	5050	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5051	POSS DUPE: INP VS OUTP	5051	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5052	EXACT DUPE: PROF XOVER TO PROF XOVER	5052	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5054	POSS DUPE: HH VS INP/NF & PCS VS INP/NF	5054	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5056	SAME PROCEDURE DIFF MODS SAME DAY	5056	SAME PROCEDURE/DIFFERENT MODIFIER NOT ALLOWED SAME DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
5057	POSSIBLE CONFLICT: NURSING FACILITY VS HOSPICE	5057	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5057	POSSIBLE CONFLICT: NURSING FACILITY VS HOSPICE	8200	RECIPIENT'S ELIGIBILITY WAS UPDATED AFTER CLAIM PAID	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
5058	POSS CONFLICT: PROVIDER TYPE 57 VS OTHERS	5058	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DA	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5059	POSS CONFLICT: PROV TYPE 39 VS PROV TYPE 57	5059	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DA	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5064	EXACT DUPLICATE: DENTAL TO DENTAL	5064	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5065	POSSIBLE DUPLICATE: DENTAL TO DENTAL	5065	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5066	POSSIBLE DUPLICATE OP HOSPICE TO OP HOSPICE CLAIM	5066	POSSIBLE DUPLICATE OP HOSPICE TO OP HOSPICE CLAIM DETAIL LINE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5068	ASC AND PROFESSIONAL CLAIMS DO NOT MATCH	5068	ASC MATCH TO PROFESSIONAL	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
5069	WELL CHECK & SICK VISITS BILLED ON THE SAME DAY	5069	WELL CHECK & SICK VISITS BILLED ON THE SAME DAY	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5070	POSS DUPE: INP VS NF OR ICIID	5070	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
5071	POSS CON: PT56 MED REHAB LTAC SPEC HOSP VS PROF	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5072	POSS CON: PT56 MED REHAB VS PT33 DME	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5073	POSS DUPLICATE IP HOSPICE TO IP HOSPICE	5073	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5074	Exact dupe current NDC equal history NDC	5074	Exact dupe of previously paid detail	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5076	EXACT DUPLICATE: NON-IHS ENCOUNTERS	5076	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5077	EXACT DUPLICATE: HOSPICE OUTPATIENT TO HOSPICE OUT	5077	Exact Duplicate: Hospice Outpatient to Hospice Outpatient Claim Detail Lines	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5081	IP VISIT SAME BILLING PROV SAME DAY NOT ALLOWED	5038	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5084	POSS CON: PT11 INPT HOSPITAL VS PT33 DME	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5085	POSS CON: PT16 ICF/IID PUBLIC VS PT33 DME	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5086	POSS CON: PT44 SWING-BED, ACUTE HOSP VS PT33 DME	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5087	POSS CON: PT68 ICF/IID PRIVATE VS PT33 DME	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5088	POSS CON: PT75 CRITICAL ACCESS HOSP VS PT33 DME	5005	CLAIM/DETAIL CONFLICTS WITH A PREVIOUSLY PAID SERVICE ON SAME OR OVERLAPPING DATE OF SERVICE	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5093	NCCI PTP CONFLICT PRACT MODS CANT BYPASS	5093	NCCI PTP conflict, practitioner, outpatient, DME - modifiers cannot solve	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 or workers compensation state regulations/ fee schedule requirements.		
5094	NCCI PTP CONFLICT PRACTITIONER MOD BYPASS POSSBL	5094	NCCI PTP conflict, practitioner, outpatient, DME - modifiers bypass possible	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 or workers compensation state regulations/ fee schedule requirements.		
5095	NCCI PTP CONFLICT OUTPATIENT MODS CANT BYPASS	5093	NCCI PTP conflict, practitioner, outpatient, DME - modifiers cannot solve	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 or workers compensation state regulations/ fee schedule requirements.		
5096	NCCI PTP CONFLICT OUTPATIENT MOD BYPASS POSSIBLE	5094	NCCI PTP conflict, practitioner, outpatient, DME - modifiers bypass possible	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 or workers compensation state regulations/ fee schedule requirements.		
5097	NCCI PTP CONFLICT DME MODS CANT BYPASS	5093	NCCI PTP conflict, practitioner, outpatient, DME - modifiers cannot solve	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 or workers compensation state regulations/ fee schedule requirements.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5098	NCCI PTP CONFLICT DME MOD BYPASS POSSIBLE	5094	NCCI PTP conflict, practitioner, outpatient, DME - modifiers bypass possible	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 or workers compensation state regulations/ fee schedule requirements.		
5099	NCCI PTP CONFLICT PAY CURRENT-REPROCESS HISTORY	5099	Previous paid service on same day to be recouped per National Correct Coding Initiative (NCCI) processing	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.
5212	CASH ADJ - SUBTOTAL OF PAID AMOUNTS IS NEGATIVE	1676	Unable To Process Your Adjustment Request. Claim Can No Longer Be Adjusted. Contact Provider Services For Further Information.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.
5248	EXACT DUPLICATE: TRANSPORTATION TO TRANSPORTATION	5048	EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5249	POSS DUPE: TRANSPORTATION TO TRANSPORTATION	5049	POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM/DETAIL	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5300	ENCOUNTER DUPLICATE - INPATIENT	5300	ENCOUNTER DUPLICATE - INPATIENT	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		
5301	ENCOUNTER DUPLICATE - OUTPATIENT	5301	ENCOUNTER DUPLICATE - OUTPATIENT	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5302	ENCOUNTER DUPLICATE - PROFESSIONAL	5302	ENCOUNTER DUPLICATE - PROFESSIONAL	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N832	Duplicate occurrence code/occurrence span code.
5302	ENCOUNTER DUPLICATE - PROFESSIONAL	5302	ENCOUNTER DUPLICATE - PROFESSIONAL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)	N832	Duplicate occurrence code/occurrence span code.
5303	ENCOUNTER DUPLICATE - DENTAL	5303	ENCOUNTER DUPLICATE - DENTAL	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N832	Duplicate occurrence code/occurrence span code.
5303	ENCOUNTER DUPLICATE - DENTAL	5303	ENCOUNTER DUPLICATE - DENTAL	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)	N832	Duplicate occurrence code/occurrence span code.
5304	ENCOUNTER DUPLICATE - PHARMACY	5304	ENCOUNTER DUPLICATE - PHARMACY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N832	Duplicate occurrence code/occurrence span code.
5304	ENCOUNTER DUPLICATE - PHARMACY	5304	ENCOUNTER DUPLICATE - PHARMACY	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)	N832	Duplicate occurrence code/occurrence span code.
5305	ENCOUNTER DUPLICATE (NET CLAIMS)	5305	ENCOUNTER DUPLICATE (NET CLAIMS)	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers compensation regulations requires CO)		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5500	1 UNIT ALLOWED PER ROLLING YEAR	5500	ONE UNIT ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5501	1 UNIT ALLOWED PER ROLLING YEAR - PA OVERRIDE	5501	ONE UNIT ALLOWED PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5502	12 UNITS ALLOWED PER ROLLING YEAR	5502	TWELVE UNITS ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5503	12 UNITS PER ROLLING YEAR - PA OVERRIDE	5503	TWELVE UNITS PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5504	1 UNIT ALLOWED PER 90 ROLLING DAYS	5504	ONE UNIT ALLOWED PER NINETY ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5505	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5505	ONE UNIT ALLOWED PER ROLLING SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5506	1 UNIT ALLOWED PER 12 ROLLING MONTHS	5506	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5507	3 UNITS ALLOWED PER DAY, SAME CLAIM - PA OVERRIDE	5507	THREE UNITS ALLOWED PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5508	4 UNITS ALLOWED PER 60 ROLLING MONTHS	5508	FOUR UNITS ALLOWED PER 60 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5509	1 UNIT ALLOWED PER 11 ROLLING MONTHS	5509	ONE UNIT ALLOWED PER 11 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5510	1 UNIT ALLOWED PER LIFETIME	5510	ONE UNIT ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5511	4 UNITS ALLOWED PER LIFETIME	5511	FOUR UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5512	1 UNIT ALLOWED PER 3 ROLLING MONTHS	5512	ONE UNIT ALLOWED PER 3 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5513	3 UNITS ALLOWED PER 6 ROLLING MONTHS	5513	THREE UNITS ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5514	2 UNITS ALLOWED PER LIFETIME	5514	TWO UNITS ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5515	1 UNIT ALLOWED PER ROLLING MONTH	5515	ONE UNIT ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5516	6 UNITS ALLOWED PER 60 ROLLING MONTHS	5516	SIX UNITS ALLOWED PER SIXTY ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5517	2 UNITS ALLOWED PER 12 ROLLING MONTHS	5517	TWO UNITS ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5518	1 UNIT ALLOWED PER 60 ROLLING MNTHS - PA OVERRIDE	5518	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5519	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5519	ONE UNIT ALLOWED PER SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5520	1 UNIT ALLOWED PER 24 ROLLING MONTHS	5520	ONE UNIT ALLOWED PER TWENTY-FOUR ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5521	1 UNIT ALLOWED PER 12 ROLLING MONTHS - PA OVERRIDE	5521	ONE UNIT ALLOWED PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5522	2 UNITS ALLOWED PER 6 ROLLING MONTHS	5522	TWO UNITS ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5523	1 UNIT ALLOWED PER 12 ROLLING MONTHS	5523	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5524	1 UNIT ALLOWED PER 48 ROLLING MONTHS	5524	ONE UNIT ALLOWED PER FORTY-EIGHT ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5525	4 UNITS ALLOWED PER 36 ROLLING MONTHS	5525	FOUR UNITS ALLOWED PER THIRTY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5526	6 UNITS ALLOWED PER 96 ROLLING MONTHS	5526	SIX UNITS ALLOWED PER NINETY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5527	6 UNITS ALLOWED PER 12 ROLLING MONTHS-PA OVERRIDE	5527	SIX UNITS ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5528	1 UNIT ALLOWED PER 9 ROLLING MONTHS	5528	ONE UNIT ALLOWED PER 9 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5529	2 UNITS ALLOWED PER ROLLING MONTH	5529	TWO UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5530	1 UNIT ALLOWED PER 8 ROLLING MONTHS	5530	ONE UNIT ALLOWED PER 8 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5531	1 UNIT ALLOWED PER 9 ROLLING MONTHS	5531	ONE UNIT ALLOWED PER 9 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5532	4 UNITS ALLOWED PER 12 ROLLING MONTHS	5532	FOUR UNITS ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5533	1 UNIT ALLOWED PER LIFETIME	5533	ONE UNIT ALLOWED PER LIFETIME	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N117	This service is paid only once in a patients lifetime.
5534	16 UNITS ALLOWED PER ROLLING MONTH	5534	SIXTEEN UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5535	40 UNITS ALLOWED PER ROLLING MONTH-PA OVERRIDE	5535	FORTY UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5536	2 UNITS ALLOWED PER CALENDAR YEAR	5536	TWO UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5537	1 UNIT ALLOWED PER DAY	5537	ONE UNIT ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5538	32 UNITS ALLOWED PER DAY	5538	THIRTY-TWO UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5539	8 UNITS ALLOWED PER DAY	5539	EIGHT UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5540	2 UNITS ALLOWED PER CALENDAR YEAR	5540	TWO UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5541	8 UNITS ALLOWED PER DAY	5541	EIGHT UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5542	1 UNIT ALLOWED PER CALENDAR MONTH	5542	ONE UNIT ALLOWED PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5543	150 UNITS ALLOWED EVERY 12 ROLLING MONTHS	5543	ONE HUNDRED-FIFTY UNITS ALLOWED EVERY TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5544	1 UNIT ALLOWED PER 90 ROLLING DAYS - PA OVERRIDE	5544	ONE UNIT ALLOWED PER NINETY ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5545	186 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5545	ONE HUNDRED EIGHTY-SIX UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5546	100 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5546	ONE HUNDRED UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5547	300 UNITS ALLOWED PER 30 ROLLING DAYS-PA OVERRIDE	5547	THREE HUNDRED UNITS ALLOWED PER THIRTY ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5548	6 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5548	SIX UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5549	16 PER 365 DAYS, 8 PER NEXT 365 DAYS--PA OVERRIDE	5549	16 UTS 1ST ROL 365 DAYS 8 UTS EA SUB ROLL 365 DAYS PCODES WITH 9 W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5551	2 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5551	TWO UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5552	3 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5552	THREE UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5553	4 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5553	FOUR UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5554	5 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5554	FIVE UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5555	6 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5555	SIX UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5556	10 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5556	TEN UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5557	15 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5557	FIFTEEN UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5558	20 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5558	TWENTY UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5559	30 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5559	THIRTY UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5560	3 UNITS ALLOWED PER LIFETIME	5560	THREE UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5561	2 UNITS ALLOWED PER 12 ROLLING MONTHS	5561	TWO UNITS ALLOWED PER TWELVE ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5562	1 UNIT ALLOWED PER 36 ROLLING M0NTHS - PA OVERRIDE	5562	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING M0NTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5563	1 UNIT ALLOWED PER 6 ROLLING MONTHS - PA OVERRIDE	5563	ONE UNIT ALLOWED PER 6 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5564	1 UNIT ALLOWED PER 24 ROLLING MONTHS - PA OVERRIDE	5564	ONE UNIT ALLOWED PER TWENTY-FOUR ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5565	31 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5565	THIRTY-ONE UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5566	60 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5566	SIXTY UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5567	50 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5567	FIFTY UNITS ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5568	4 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5568	FOUR UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5569	2 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5569	TWO UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5570	12 UNITS ALLOWED PER 12 ROLLING MONTHS-PA OVERRIDE	5570	TWELVE UNITS ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5571	1 UNIT ALLOWED PER 6 ROLLING MONTHS - PA OVERRIDE	5571	ONE UNIT ALLOWED PER 6 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5572	1 UNIT ALLOWED PER ROLLING MONTH - PA OVERRIDE	5572	ONE UNIT ALLOWED PER ROLLING MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5573	3 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5573	THREE UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5592	1 UNIT ALLOWED PER 24 ROLLING MONTHS - PA OVERRIDE	5592	ONE UNIT ALLOWED PER TWENTY-FOUR ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5593	1 UNIT ALLOWED PER 60 ROLLING MONTHS - PA OVERRIDE	5593	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5594	1 UNIT ALLOWED PER 12 ROLLING MONTHS - PA OVERRIDE	5594	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5595	4 UNITS ALLOWED PER ROLLING YEAR - PA OVERRIDE	5595	FOUR UNITS ALLOWED PER ROLLING YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5596	1 UNIT ALLOWED PER 36 ROLLING MONTHS - PA OVERRIDE	5596	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5597	1 UNIT ALLOWED PER ROLLING MONTH	5597	ONE UNIT ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5598	2 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5598	TWO UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5599	1 UNIT ALLOWED PER 3 ROLLING YEARS - PA OVERRIDE	5599	ONE UNIT ALLOWED PER 3 ROLLING YEARS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5600	2 UNITS ALLOWED PER 24 ROLLING MONTHS -PA OVERRIDE	5600	TWO UNITS ALLOWED PER TWENTY-FOUR ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5601	9 UNITS ALLOWED PER 11 ROLLING MONTHS	5601	NINE UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5602	1 UNIT ALLOWED PER 6 ROLLING MONTHS	5602	ONE UNIT ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5603	4 UNITS ALLOWED PER DAY	5603	FOUR UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5605	2 UNITS ALLOWED PER 60 ROLLING M0NTHS -PA OVERRIDE	5605	TWO UNITS ALLOWED PER SIXTY ROLLING M0NTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5606	100 UNITS ALLOWED PER 1 ROLLING M0NTH -PA OVERRIDE	5606	ONE HUNDRED UNITS ALLOWED PER 1 ROLLING M0NTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5607	20 UNITS ALLOWED PER LIFETIME - PA OVERRIDE	5607	TWENTY UNITS ALLOWED PER LIFETIME WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5608	16 UNITS ALLOWED PER DAY - PA OVERRIDE	5608	16 UNITS ALLOWED PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5609	1 UNIT ALLOWED PER 7 ROLLING DAYS	5609	ONE UNIT ALLOWED PER 7 ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5610	2 UNITS ALLOWED PER LIFETIME	5610	TWO UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5611	24 UNITS ALLOWED PER DAY	5611	TWENTY-FOUR UNITS ALLOWED PER DAY	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5612	12 ENCOUNTERS ALW PER CALENDAR YEAR - PA OVERRIDE	5612	TWELVE ENCOUNTERS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5613	2 UNITS ALLOWED PER CALENDAR YEAR	5613	TWO UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5614	2 UNITS ALLOWED PER CALENDAR MONTH	5614	TWO UNITS ALLOWED PER 1 CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5615	2 UNITS ALLOWED PER 6 CALENDAR MONTHS	5615	TWO UNITS ALLOWED PER 6 CALENDAR MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5616	2 UNITS ALLOWED PER 11 ROLLING MONTHS-PA OVERRIDE	5616	TWO UNITS ALLOWED PER ELEVEN ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5617	1 UNIT ALLOWED PER 5 ROLLING YEARS	5617	ONE UNIT ALLOWED PER 5 ROLLING YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5618	2 UNITS ALLOWED PER 90 ROLLING DAYS-PA OVERRIDE	5618	TWO UNITS ALLOWED PER NINETY ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5619	24 ENCOUNTERS ALLWED PER CALENDAR YEAR-PA OVERRIDE	5619	TWENTY-FOUR ENCOUNTERS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5620	1 UNIT ALLOWED PER DAY	5620	ONE UNIT ALLOWED PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5621	1 UNIT ALLOWED PER 9 ROLLING MONTHS - PA OVERRIDE	5621	ONE UNIT ALLOWED PER NINE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5622	1 UNIT ALLOWED PER DAY	5622	ONE UNIT ALLOWED DAY PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5623	16 PER 365 DAYS, 8 PER NEXT 365 DAYS--PA OVERRIDE	5623	16 UTS 1ST ROL 365 DAYS 8 UTS EA SUB ROLL 365 DAYS PCODES WITH G W/O PA	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5624	1 UNIT ALLOWED PER CALENDAR YEAR	5624	ONE UNIT ALLOWED PER CALENDAR YEAR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5626	16 UNITS ALLOWED PER DAY	5626	16 UNITS ALLOWED PER DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).
5627	1 UNIT ALLOWED PER 11 ROLLING MONTHS - PA OVERRIDE	5627	ONE UNIT ALLOWED PER ELEVEN ROLLING MONTHS WITHOUT PRIOR APPROVAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5628	1 UNIT ALLOWED PER 181 ROLLING DAYS	5628	ONE UNIT ALLOWED PER ONE HUNDRED EIGHTY-ONE ROLLING DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5629	1 UNIT ALLOWED PER LIFETIME	5629	ONE UNIT ALLOWED PER LIFETIME	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5630	1 UNIT ALLOWED PER 90 ROLLING DAYS	5630	ONE UNIT ALLOWED PER NINETY ROLLING DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5631	1 UNIT ALLOWED PER DAY	5631	ONE UNIT ALLOWED PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5632	1 UNIT ALLOWED PER 270 ROLLING DAYS - PA OVERRIDE	5632	ONE UNIT ALLOWED PER 270 ROLLING DAYS WITHOUT PRIOR APPROVAL	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N495	Missing Supplemental Medical Report.
5633	1 UNIT ALLOWED PER 175 ROLLING DAYS - PA OVERRIDE	5633	ONE UNIT ALLOWED PER ONE HUNDRED SEVENTY-FIVE ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5647	1 UNIT ALLOWED PER CALENDAR MONTH	5647	ONE UNIT ALLOWED PER CALENDAR MONTH	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
5648	$2500 ALLOWED PER CALENDAR YEAR	5648	$2500 ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5649	1 UNIT ALLOWED PER DAY	5649	ONE UNIT ALLOWED PER DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5650	24 UNITS ALLOWED PER CALENDAR YEAR	5650	TWENTY-FOUR UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5652	4 UNITS ALLOWED PER LIFETIME	5652	FOUR UNITS ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5653	2 UNITS ALLOWED PER 36 ROLLING MONTHS	5653	TWO UNITS ALLOWED PER THIRTY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5654	1 UNIT ALLOWED PER DAY	5654	ONE UNIT ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5655	2 UNITS ALLOWED PER 12 ROLLING MNTHS - PA OVERRIDE	5655	TWO UNITS ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5656	1 UNIT ALLOWED PER 36 ROLLING MONTHS	5656	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.
5657	1 UNIT ALLOWED PER 36 ROLLING MNTHS - PA OVERRIDE	5657	ONE UNIT ALLOWED PER THIRTY-SIX ROLLING M0NTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5658	1 UNIT ALLOWED PER LIFETIME - PA OVERRIDE	5658	ONE UNIT ALLOWED PER LIFETIME WITHOUT PRIOR APPROVAL	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5659	1 UNIT ALLOWED PER 12 ROLLING MONTHS	5659	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5660	4 UNITS ALLOWED PER 60 ROLLING MNTHS - PA OVERRIDE	5660	FOUR UNITS ALLOWED PER 60 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5661	48 HOURS PER ENCOUNTER - PA OVERRIDE	5661	FORTY-EIGHT HOURS ALLOWED PER ENCOUNTER	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5662	RENTAL PRICE EXCEEDS PURCHASE PRICE	5662	RENTAL PRICE EXCEEDS PURCHASE PRICE	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
5663	AMOUNT REDUCED BY HIST RENTAL PYMT	5663	AMOUNT REDUCED BY PREVIOUS RENTAL PAYMENT(S)	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.
5664	1 UNIT PER 12 ROLLING MONTHS - PA OVERRIDE	5664	ONE UNIT PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5665	1 UNIT PER 60 ROLLING MONTHS - PA OVERRIDE	5665	ONE UNIT PER 60 ROLLING MONTHS WITHOUT PRIOR APPROVAL	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5666	40 UNITS ALLOWED PER CAL MONTH - PA OVERRIDE	5666	40 UNITS ALLOWED PER CAL MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5667	20 UNITS ALLOWED PER CAL MONTH - PA OVERRIDE	5667	20 UNITS ALLOWED PER CAL MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5668	8 UNITS ALLOWED PER CALENDAR YEAR	5668	8 UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5669	1 UNIT ALLOWED PER LIFETIME	5669	1 UNIT ALLOWED PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5670	500 UNITS ALLOWED PER CALENDAR MONTH PA OVERRIDE	5670	FIVE HUNDRED UNITS ALLOWED PER CALENDAR MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5671	1 UNIT PER 12 ROLLING MONTHS - PA OVERRIDE	5671	ONE UNIT ALLOWED PER TWELVE ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5672	1 UNIT ALLOWED PER 90 ROLLING DAYS	5672	ONE UNIT ALLOWED PER NINETY ROLLING DAYS	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5673	1 UNIT ALLOWED PER 2 ROLLING MONTHS - PA OVERRIDE	5673	ONE UNIT ALLOWED PER 2 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5674	3 UNITS ALLOWED PER 2 ROLLING MONTHS - PA OVERRIDE	5674	THREE UNITS ALLOWED PER 2 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5675	5 UNITS ALLOWED PER 2 ROLLING MONTHS PA OVERRIDE	5675	FIVE UNITS ALLOWED PER 2 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5676	2 UNITS ALLOWED PER 6 ROLLING MONTHS -PA OVERRIDE	5676	TWO UNITS ALLOWED PER 6 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5677	2 UNITS ALLOWED PER 24 ROLLING MONTHS-PA OVERRIDE	5677	TWO UNITS ALLOWED PER 24 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5678	2 UNITS ALLWD PER 36 ROLLING MONTHS - PA OVERRIDE	5678	TWO UNITS ALLOWED PER 36 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5679	50 UNITS ALLOWED PER CALENDAR YEAR	5679	50 UNITS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5680	2 UNITS ALLOWED PER LIFETIME	5680	TWO UNITS ALLOWED PER LIFETIME	149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.
5681	1 UNIT PER 90 ROLLING DAYS - PA OVERRIDE	5681	ONE UNIT ALLOWED PER 90 ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5682	1 UNIT ALLOWED PER 6 ROLLING MONTHS - PA OVERRIDE	5682	ONE UNIT ALLOWED PER 6 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5683	50 UNITS ALLOWED PER CALENDAR YEAR - PA OVERRIDE	5683	50 UNITS ALLOWED PER CALENDAR YEAR WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5684	2 UNITS ALLOWED PER 60 ROLLING MONTHS	5684	TWO UNITS ALLOWED PER 60 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5685	2 UNITS ALLOWED PER 12 ROLLING MONTHS	5685	TWO UNITS ALLOWED PER 12 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5686	4 UNITS ALLOWED PER DAY - PA OVERRIDE	5686	4 UNITS ALLOWED PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5688	1 SER DATE W/IN 180 ROLL DAYS - PA OVERRIDE	5688	1 SERVICE DATE WITHIN 180 ROLLING DAYS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5689	4 UNITS ALLOWED PER CALENDAR WEEK	5689	4 UNITS ALLOWED PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5690	26 SESSIONS ALLOWED PER CALENDAR YEAR - PA OVERRID	5690	26 SESSIONS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5691	18 SESSIONS ALLOWED PER CALENDAR YEAR - PA OVERRID	5691	18 SESSIONS ALLOWED PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5692	1 UNIT ALLOWED PER ROLLING YEAR - PA OVERRIDE	5692	ONE UNIT ALLOWED PER ROLLING YEAR	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5693	4 UNITS ALLOWED PER CALENDAR MONTH	5693	4 UNITS ALLOWED PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5694	16 UNITS ALLOWED PER DAY - PA OVERRIDE	5694	16 UNITS PER DAY WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5695	3 OCCURRENCES ALLWD WIN 90 ROLL DAYS - PA OVERRIDE	5695	3 OCCURRENCES WITHIN 90 ROLL DAYS W/OUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5696	2 UNITS ALLOWED PER CALENDAR MONTH - PA OVERRIDE	5696	2 UNITS PER CAL MONTH WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5697	20 UNITS PER 12 ROLLING MONTHS - PA OVERRIDE	5697	20 UNITS PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5698	3 UNITS PER 12 ROLLING MONTHS - PA OVERRIDE	5698	3 UNITS PER 12 ROLLING MONTHS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5699	1 UNIT ALLOWED PER DAY	5699	1 UNIT ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5700	5 UNITS ALLOWED PER CALENDAR WEEK	5700	5 UNITS ALLOWED PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5701	1 UNIT ALLOWED PER 6 ROLLING MONTHS - PA OVERRIDE	5505	ONE UNIT ALLOWED PER ROLLING SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5702	6 UNITS ALLOWED PER LIFETIME - PA OVERRIDE	6110	DENTAL SERVICES LIFETIME LIMIT HAS BEEN MET	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
5703	1 UNIT ALLOWED PER 60 ROLLING MONTHS	5703	ONE UNIT ALLOWED PER SIXTY ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5704	24 HOURS ALLOWED PER DAY	5704	Habilitation units exceeded 24 hours a day.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5705	3 DATES ALLOWED PER 90 DAYS	5705	Three dates allowed in 90 days	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5706	1 DATE ALLOWED PER 180 DAYS	5706	One date allowed in 180 days	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5707	2 UNITS ALLOWED PER CALENDAR MONTH	5707	Two units allowed in a calendar month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5708	1 UNIT ALLOWED PER 90 DAYS	5708	One unit allowed in 90 days	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5709	4 UNITS ALLOWED PER CALENDAR YEAR	5709	Four units allowed in a calendar year	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5710	6 UNITS ALLOWED PER 12 MONTHS	5710	Six units allowed in 12 months	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5711	26 UNITS ALLOWED PER CALENDAR YEAR	5711	26 units allowed in a calendar year	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5712	10 UNITS ALLOWED PER CALENDAR MONTH	5712	10 units allowed in a calendar month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5713	5 UNITS ALLOWED PER CALENDAR MONTH	5713	5 units allowed in a calendar month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5716	LIMIT OF 12 HOURS PER NPI PER DAY	5716	LIMIT OF 12 HOURS PER NPI PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5717	4 UNITS ALLOWED PER CALENDAR WEEK - PA OVERRIDE	5717	4 UNITS ALLOWED PER CALENDAR WEEK	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5718	16 UNITS ALLOWED PER DAY - PA OVERRIDE	5718	16 UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5719	160 UNITS ALLOWED PER CALENDAR MONTH - PA OVERRIDE	5719	160 UNITS ALLOWED PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5724	8 UNITS ALLOWED PER DAY - PA OVERRIDE	5724	8 UNITS ALLOWED PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5725	24 ENCOUNTERS PER ROLLING 12 MOS - PA OVERIDE	5725	24 ENCOUNTERS ALLOWED PER 12 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5726	$3000 ALLOWED PER FISCAL YEAR (JULY 1 - JUNE 30)	5726	$3000 ALLOWED PER FISCAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5727	7 VISITS ALLOWED PER ROLLING YEAR	5727	7 visits allowed per rolling year	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5728	3 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	5728	THREE UNITS ALLOWED PER DELIVERY WITHOUT PRIOR APPROVAL	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
5729	4 UNITS ALLOWED PER C-SECTION DELIVERY-PA OVERRIDE	5729	FOUR UNITS ALLOWED PER C-SECTION DELIVERY WITHOUT PRIOR APPROVAL	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
5730	ID WAIVER-1 UNIT PER 3 ROLLING MOS - PA OVERRIDE	5730	1 UNIT ALLOWED PER 3 ROLLING MONTHS - PA OVERRIDE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5731	200 UNITS ALLOWED PER ROLLING MONTH	5731	200 UNITS ALLOWED PER ROLLING MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
5732	2 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	5732	2 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
5733	2 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	5733	2 UNITS ALLOWED PER DELIVERY - PA OVERRIDE	198	Precertification/notification/authorization/pre-treatment exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
5734	2 Units Allowed Per 2 Rolling Year	5734	2 Units Allowed Per 2 Rolling Year	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5735	LIMIT OF FORTY HOURS PER WEEK PA OVERRIDE	5735	LIMIT OF FORTY HOURS PER WEEK.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5737	1 UNIT ALLOWED PER 2 ROLLING MONTHS	5737	ONE UNIT ALLOWED PER 2 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5739	6 UNITS ALLOWED PER 6 ROLLING MONTHS	5739	6 UNITS ALLOWED PER 6 ROLLING MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5740	200 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	5740	200 UNITS ALLOWED PER ROLLING MONTH - PA OVERRIDE	119	Benefit maximum for this time period or occurrence has been reached.		

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
5743	24 UNITS ALLOWED PER CALENDAR MONTH - PA OVERRIDE	5743	24 UNITS ALLOWED PER CALENDAR MONTH - PA OVERRIDE	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5744	2 UNITS ALLOWED PER 3 ROLLING YEARS - PA OVERRIDE	5744	TWO UNITS ALLOWED PER 3 ROLLING YEARS WITHOUT PRIOR APPROVAL	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
5747	75 UNITS ALLOWED PER ROLLING YEAR	5747	75 Units Allowed Per Rolling Year	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5748	56 UNITS ALLOWED PER ROLLING MONTH	5748	56 Units Allowed Per Rolling Month	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
5749	4 MODALITIES AND/OR THER PROC PER DAY	5749	4 modalities and/or therapeutic procedures allowed in one day	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6000	MANUAL PRICING REQUIRED	617	Claim denied- please resubmit with correct units.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N430	Procedure code is inconsistent with the units billed.
6000	MANUAL PRICING REQUIRED	653	CLAIM REQUIRES MANUAL PRICING. PLEASE ATTACH INVOICE FOR MEDICAL SERVICES.	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N445	Missing document for actual cost or paid amount.
6100	INVALID COMB OF PROCEDURES SAME DAY	6100	INVALID COMBINATION OF PROCEDURES BILLED SAME CALENDAR DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6101	INTRAORAL IMAGE NOT ALLOWED SAME DAY	6101	INTRAORAL IMAGE PROCEDURES NOT ALLOWED SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6102	ANESTHESIA NOT ALLOWED SAME DAY	6102	ANESTHESIA SEVICES NOT ALLOWED SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
6103	T1017 & G9012 CANNOT BE BILLED ON SAME DAY	6103	T1017 & G9012 CANNOT BE BILLED ON SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6104	EVALUATION PREVIOUSLY PAID FOR CALENDAR YEAR	6104	EVALUATION PREVIOUSLY PAID FOR CALENDAR YEAR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6105	EVALUATION PREVIOUSLY PAID WITHIN 90 DAYS	6105	EVALUATION PREVIOUSLY PAID WITHIN 90 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6106	INFUSION PUMP ALLOWED 1/366 DAYS	6106	INFUSION PUMP PREVIOUSLY PAID WITHIN 366 DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6107	INVALID COMBINATION OF PROCEDURE CODES	6107	INVALID COMBINATION OF PROCEDURE CODES BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6108	DENTAL SVCS NOT ALLOWED WITHIN 61 DAYS	6108	DENTAL SERVICES NOT ALLOWED WITHIN 61 DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6109	DENT SVCS NOT ALLWD WITHIN 180 DAYS AFTER SEALANT	6109	DENTAL SERVICES NOT ALLOWED WITHIN 180 DAYS AFTER SEALANT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6110	DENTAL SVCS ALLOWED PER LIFETIME	6110	DENTAL SERVICES LIFETIME LIMIT HAS BEEN MET	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6111	DENT SVCS NOT ALLWD UP TO 91 DAYS AFTER EXTRACTION	6111	DENTAL SERVICES NOT ALLOWED UP TO 91 DAYS BEFORE RELATED CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6112	ADULT DAY CARE PROCEDURES NOT ALLOWED SAME DAY	6112	ADULT DAY CARE PROCEDURES NOT ALLOWED SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6113	SEALANT ON SAME TOOTH ALLOWED ONCE PER LIFETIME	6113	SEALANT ON SAME TOOTH ALLOWED ONCE PER LIFETIME	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N117	This service is paid only once in a patients lifetime.
6114	C-SECTION OB VS VAG OB	6114	C-SECTION DELIVERY DATE CONFLICTS WITH VAGINAL DELIVERY DATE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.
6115	DENTURE PROCS NOT REIMBURSEABLE WITHIN 180 DAYS	6115	DENTAL PROCEDURES NOT ALLOWED UP TO 180 DAYS AFTER HISTORY CLAIM	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
6116	CARE AFTER DEL-GLOBAL DEL NOT REIMB WITHIN 90 DAYS	6116	CARE AFTER DELIVERY - GLOBAL DELIVERY NOT ALLOWED WITHIN 90 DAYS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6117	VAG OB VS C-SECTION OB	6117	VAGINAL DELIVERY CONFLICTS WITH C-SECTION DELIVERY DATE	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.
6118	PANORAMIC XRAY CONFLICT	6118	PANORAMIC XRAY PROCEDURE CONFLICT	119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.
6119	99238 & 99239 CANT BE BILLED DURING SAME HOSP STAY	6119	99238 & 99239 CAN'T BE BILLED DURING SAME HOSPITAL STAY - ONLY ONE CODE ALLOWED DURING HOSPITAL DISCHARGE AND CAN ONLY BE BILLED ONCE.	114	Procedure/product not approved by the Food and Drug Administration.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6120	DNY PROC WITH RB/MS IF RR CDE PD W/IN SAME CAL MTH	6120	MODIFIERS RB/MS CONFLICTS WITH PREVIOUSLY PAID RR MODIFIER WITHIN SAME CALENDAR MONTH	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6121	RECEMENT/REBOND CROWN NOT ALWD WITHIN 12 MONTHS	6121	RECEMENT/REBOND CROWN NOT ALLOWED UP TO 12 MONTHS AFTER PREVIOUSLY PAID DENTAL PROCEDURE	273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6122	PROCEDURE NON-COVERED SAME ICN	6122	PROCEDURE(S) NON-COVERED ON THE SAME CLAIM	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
6123	ADULT/NEONATAL DAYS NOT ALLOWED ON SAME ICN	6123	ADULT/NEONATAL DAYS NOT ALLOWED ON THE SAME CLAIM	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N15	Services for a newborn must be billed separately.
6124	PSYCHIATRIC OFFICE VISITS NOT ALLOWED SAME DAY	6124	PSYCHIATRIC OFFICE VISITS NOT ALLOWED SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6125	MULTIPLE PROCEDURE RULE NOT FOLLOWED	6125	MULTIPLE SURGICAL PROCEDURES ON SAME DATE OF SERVICE	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
6127	BILATERAL PROCEDURE RULE NOT FOLLOWED	6127	BILATERAL PROCEDURE RULE NOT FOLLOWED	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
6128	PRESUMPTIVE G CODE SAME DAY	6128	PRESUMPTIVE PROCEDURES NOT ALLOWED SAME DAY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
6129	NOT ALLWD IN SAME CAL MONTH OTH EQUIPMENT/SUPPLIES	6129	NOT ALLWD IN SAME CAL MONTH AS OTHER EQUIPMENT/SUPPLIES	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6130	T1016 U1 NOT ALLWD W T1016 U1 W/IN 11 RLG CAL MO	6130	T1016 U1 NOT ALLWD W T1016 U1 W/IN 11 RLG CAL MO	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6131	ASST SURG MOD AND CO-SURG MOD NOT ALWD ON SAME DOS	6131	ASSISTANT SURGEON MODIFIER AND CO-SURGEON MODIFIER NOT ALLOWED ON THE SAME DATE OF SERVICE	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
6133	PROCEDURE D7261/D7241 CONFLICT	6133	PROCEDURE D7261/D7241 CONFLICT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6134	UNBUNDLING OF TECH/PROF MODS	6134	UNBUNDLING OF TECH/PROF MODS	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6135	Possible Conflict of Procedures S5150 and T2031	6135	S5051 suspends if T2031 has paid for the same date of service.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N47	Claim conflicts with another inpatient stay.
6135	Possible Conflict of Procedures S5150 and T2031	8202	Procedure T2031 cannot pay when procedure S5150 pays more than 24 units (6 hours) on same DOS.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6136	DENTAL SVCS NOT ALLOWED ON SAME DATE OF SERVICE	6136	DENTAL SERVICES NOT ALLOWED ON SAME DATE OF SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6138	CCBHC/CLINIC SVCS NOT ALLOWED SAME DAY	6138	CCBHC/CLINIC SERVICES NOT ALLOWED SAME DAY	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
6139	T1016 NO MOD NOT ALWD W T1016 U1-U4 SAME CAL MO	6139	T1016 NO MOD NOT ALWD W T1016 U1-U4 SAME CAL MO	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6140	SAME PROCEDURE SAME DAY DIFFERENT MODIFIERS	6140	SAME PROCEDURE, SAME DAY, DIFFERENT MODIFIERS	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6141	LAB TESTS CANNOT BE BILLED SAME DAY	6141	LAB TESTS CANNOT BE BILLED ON SAME DAY	B20	Procedure/service was partially or fully furnished by another provider.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6142	INVALID HOSPICE REV/COMB SAME DAY CLAIM DETAIL	6142	INVALID HOSPICE REV/COMB SAME DAY CLAIM DETAIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.
6143	NOT ALLOWED WITHIN 60 DAYS FROM EXTRACTION DATE	6143	NOT ALLOWED WITHIN 60 DAYS FROM EXTRACTION DATE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6144	MODIFIER U8 ALLOWED ONCE PER 12 ROLLING MONTHS	6144	MODIFIER U8 IS PAYABLE ONCE PER ROLLING YEAR FOR SPECIALIZED FOSTER CARE SERVICES, PROVIDER TYPE 86	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6145	TELEHEALTH CALL NOT ALLOWED AFTER E&M SERVICE	6145	TELEHEALTH CALL NOT ALLOWED AFTER E&M SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6146	E&M SERVICE NOT ALLOWED AFTER TELEHEALTH CALL	6146	E&M SERVICE NOT ALLOWED AFTER TELEHEALTH CALL	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6147	TELEHEALTH CALL NOT ALLOWED BEFORE E&M SERVICE	6147	TELEHEALTH CALL NOT ALLOWED BEFORE E&M SERVICE	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
6148	ID WAIVER-DENT SVCS NOT ALLWD UP TO 91 DAYS AFTER	6148	DENT SVCS NOT ALLWD UP TO 91 DAYS AFTER RELATED CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6151	NEW PATIENT VISIT WITHIN 3 YEARS	6151	NEW PATIENT VISIT WITHIN 3 YEARS	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
6500	REQUIRED TO BILL WITH OTHER PROCEDURE	6500	PROCEDURE NOT REIMBURSEABLE WITHOUT PRIMARY CODE	107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.
6501	EPIDURAL CLM REVIEW NO PRIMARY PROC WITHIN 10 DAYS	6501	EPIDURAL CLM REVIEW NO PRIMARY PROC WITHIN 10 DAYS	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6502	PROSTHETIC NOT BILLED IN LAST 365 DAYS	6502	PROCEDURE NOT REIMBURSEABLE WITHOUT PREVIOUSLY PAID PROSTHETIC PROCEDURE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.
6503	CATARACT SURGERY NOT PAID BY MCARE PART B	6503	CATARACT SURGERY HAS NOT BEEN PAID BY MEDICARE PART B	22	This care may be covered by another payer per coordination of benefits.	N598	Health care policy coverage is primary.
6504	T1016 MOD U1 NOT PAID DURING PREVIOUS CALENDAR MO	6504	T1016 MOD U1 NOT PAID DURING PREVIOUS CALENDAR MO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N674	Not covered unless a pre-requisite procedure/service has been provided.
6505	T1016 MOD U2 NOT PAID DURING PREVIOUS CALENDAR MO	6505	T1016 MOD U2 NOT PAID DURING PREVIOUS CALENDAR MO	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6506	T1016 MOD U3 NOT PAID DURING PREVIOUS CALENDAR MO	6506	T1016 MOD U3 NOT PAID DURING PREVIOUS CALENDAR MO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N674	Not covered unless a pre-requisite procedure/service has been provided.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6507	PHARM CLM FOR NEW PRESCRIP NOT PD IN LAST 30 DAYS	6507	RECIPIENT HAS NO NEW PRESCRIPTION IN THE LAST 30 DAYS	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6508	PAID DENTAL EXAM CODE NOT ON FILE	6508	PAID DENTAL EXAM CODE NOT ON FILE	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6509	PROVIDER TYPE 86 ELIGIBILITY CHECKLIST NOT RECEIVE	6509	PROVIDER TYPE 86 ELIGIBILITY CHECKLIST NOT RECEIVED	119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.
6510	ADD-ON CODE BILLED W/O PAID PRIMARY WITHIN 2 DAYS	6510	ADD-ON CODE BILLED W/O PAID PRIMARY WITHIN 2 DAYS	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.
6511	ADD-ON CODE BILLED W/O PAID PRIMARY	6511	ADD-ON CODE BILLED W/O PAID PRIMARY	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
6513	ID WAIVER-PROCEDURE NOT IN CONJUNCTION WITH BIOPSY	6513	PROCEDURE NOT IN CONJUNCTION WITH BIOPSY	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).
6514	Modifier JW not billed on same claim	6514	Claim has procedure with modifier JW and no procedure without modifier JW billed on same claim	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
6515	ADD-ON CODE BILLED W/O PAID PRIMARY LENS	6511	ADD-ON CODE BILLED W/O PAID PRIMARY	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N122	Add-on code cannot be billed by itself.
6516	10 K0606 NOT PAID DURING PREVIOUS 60 CALENDAR MO	6516	LESS THAN 10 UNITS OF K0606 PAID DURING PREVIOUS 60 CALENDAR MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
7200	MISCELLANEOUS CLAIMS XTEN ERROR	7200	This claim/service is pending for Xten program review. No action is needed on your part.	133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		
7200	MISCELLANEOUS CLAIMS XTEN ERROR	7201	Denied by ClaimXten based on program policies.	204	This service/equipment/drug is not covered under the patients current benefit plan		
7201	DENIED - CLAIMS XTEN RESPONSE FAILED	7201	Denied by ClaimXten based on program policies.	204	This service/equipment/drug is not covered under the patients current benefit plan		
7211	PROCEDURE IS INVALID FOR PATIENT'S AGE	7211	Procedure Is Invalid For Patient's Age	6	The procedure/revenue code is inconsistent with the patients age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patients age.

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

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

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
7242	DX TO PX COMPARISON PROCEDURE DENIED	7242	Claim Line Flagged for Unexpected Diagnosis with Procedure Billed.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
7244	MEDICAL VISIT DENIED (CLAIMREVIEW)	7244	ESTABLISHED PATIENT - NEW VISIT PX NOT ALLOWED	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N30	Patient ineligible for this service.
7245	PX ADDED DUE TO NEW VISIT FREQ CODE REPLACEMENT	7245	Px Added Due to New Visit Freq Code Replacement.	B16	New Patient qualifications were not met.	N113	Only one initial visit is covered per physician, group practice or provider.
7261	INVALID PROCEDURE CODE	7261	Invalid Procedure Code.	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).
7269	MODIFIER NOT VALID FOR THE DATE OF SERVICE	7269	Modifier Not Valid for the Date of Service.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION	7270	Invalid Modifier/Procedure Code Combination.	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
7281	PROCEDURE NOT INDICATED FOR DIAGNOSIS	7281	Procedure Code Not Indicated for Diagnosis.	11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

ERROR_CODE	ERROR_CODE_DESCRIPTION	EOB_CODE	EOB_CODE_DESCRIPTION	REASON_CODE	REASON_CODE_DESCRIPTION	REMARK_CODE	REMARK_CODE_DESCRIPTION
7292	PROCEDURE EXCEEDS MAXIMUM NUMBER ALLOWED PER DAY	7292	Procedure Exceeds Maximum Number Allowed Per Day.	119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
7293	ADDITIONAL UNITS MUST BE BILLED WITH ADD-ON CODES	7293	Additional Units Must Be Billed with Add-On Codes.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
7294	PROCEDURE INCLUDED IN GLOBAL PROCEDURE	7294	Procedure Included in Global Procedure.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.
7295	PX IS A COMPONENT OR CONFLICTING PROCEDURE	7295	PX is a Component or Conflicting Procedure.	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
7500	BILLING PROVIDER ON PREPAYMENT REVIEW	3090	Billing provider under review - suspend all claims	243	Services not authorized by network/primary care providers.	N95	This provider type/provider specialty may not bill this service.
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW	3051	Rendering provider under review - suspend all claims.	185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		