

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0001	PLEASE VERIFY THE DATES OF SERVICE. HEADER FROM DATE OF SERVICE IS MISSING OR INVALID.
0002	THE ADMITTING DATE OF SERVICE IS MISSING/INVALID OR LATER THAN THE FROM DOS
0003	VERIFY THE DATES OF SERVICE. THE TO DATE OF SERVICE IS INVALID, MISSING, FUTURE DATE OR LESS THAN THE FROM DATE OF SERVICE.
0004	PROCEDURE IS LIMITED TO ONE TIME IN A YEAR PERIOD. IF YOU BILLED FOR MORE THAN ONE UNIT ON THIS CLAIM, REBILL FOR ONE UNIT ONLY.
0005	EACH PROV IS LIMITED TO BILLING ONLY 1 OF THE FOLLOWING PROCEDURES (HOSP ADM, ER VIS, CONSULT, OV) MEMBER/SAME DOS. YOU HAVE ALREADY RECEIVED PAYMENT FOR 1OF
0006	THE DISCHARGE DATE IS MISSING OR INVALID
0007	TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES
0008	REQUEST FOR PAYMENT RECD PAST MEDICAID FILING LIMIT. CLAIM MUST BE FILED WITHIN 1 YR OF THE DOS OR WITHIN 6 MONTHS OF MEDICARE PD DATE.
0009	CLAIM DENIED. RESEARCH DATA UNAVAILABLE TO PROCESS CLAIM PLEASE RESUBMIT CLAIM WITH ITEMIZED BILL. SUMMARY STATEMENT FOR ENTIRE ADMISSION.
0010	CLAIM DENIED. PLEASE RESUBMIT CLAIM WITH ANESTHESIA REPORT
0011	NUMBER OF UNITS BILLED IS NOT EQUAL TO DATE SPAN
0012	ONLY ONE UNIT IS PAYABLE PER DATE OF SERVICE FOR THIS SERVICE. UNITS OF SERVICE CHANGED TO ONE.
0013	DISCHARGE DATE IS PRIOR TO THROUGH DATE OF SERVICE
0014	CODE INDICATING SUPERVISING PROFESSIONAL IS MISSING/INVALID
0015	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO THE FOLLOWING
0016	CLAIM/DETAIL DENIED. PROCEDURE IS LIMITED TO TRAUMA RELATED INJURIES.
0017	LONG TERM CARE DAYS BILLED IS GREATER THAN THE NUMBER OF DAYS IN BILLING MONTH
0018	CLAIM DENIED. ACCOMMODATION/ANCILLARY CODE MISSING OR INVALID.
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.
0020	MEDICARE DOCUMENTATION NOT ATTACHED
0021	CLAIM DENIED. PHYSICIAN ON REPORT AND PHYSICIAN BILLING DO NOT MATCH.
0022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS
0023	CLAIM DENIED. NO PHYSICIAN PATIENT CONTACT.
0024	THE DETAIL BILLED AMOUNT IS MISSING OR INVALID
0025	CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.
0026	CLAIM DENIED. LONG TERM CARE SUPPLEMENTAL BILLING MUST BE SUBMITTED AS AN ADJUSTMENT.
0027	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM.
0028	CLAIM/DETAIL DENIED. DATA ILLEGIBLE. PLEASE RESUBMIT.
0029	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFIC PROCEDURE CODE AND CRITERIA SET FOR REVIEW.
0030	MILEAGE RATE MISSING OR ZEROS
0031	CLAIM DENIED. LEVEL OF CARE MISSING. PLEASE CORRECT AND RESUBMIT.
0032	CLAIM DENIED. UNIT OF MEASURE INVALID. DOES NOT MATCH NDC UNIT OF MEASURE.
0033	NUMBER OF UNITS BILLED LESS THAN 30 FOR INSULIN SYRINGES
0034	DENIED BY MEDICARE
0035	DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THIS DATE OF SERVICE
0036	CLAIM DENIED. ONLY 1 DATE OF SERVICE ALLOWED PER CLAIM FORM.
0037	MODEL WAIVER 1 MEMBER LIMITED TO 24 HOURS OF NURSING SERVICES PER DATE OF SERVICE.
0038	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PLACE OF SERVICE.
0039	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DATE OF SERVICE
0040	CLAIM/DETAIL DENIED. TYPE OF BILL INVALID OR MISSING.
0041	DRUG MANAGEMENT AND MEDICAL PSYCHOTHERAPY NOT ALLOWED FOR SAME DOS, PROVIDER, PROVIDER OR MEMBER
0042	CLAIM DENIED. COINSURANCE AND/OR DEDUCTIBLE GREATER ON CLAIM THAN EOMB.
0043	CLAIM DENIED. VOUCHER NUMBER MISSING OR INVALID.
0044	CLAIM DETAIL DENIED. REVENUE CODE MISSING OR INVALID.
0045	TYPE OF BILL INVALID FOR PROVIDER TYPE
0046	CLAIM DENIED. HCPCS CODE BILLED INVALID/OBSOLETE. RESUBMIT WITH CORRECT CODE.

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0047	PROFESSIONAL COMPONENT BILLED. CLAIM MANUALLY PRICED TO MAXIMUM ALLOWABLE
0048	CLAIM DENIED. MEDICARE PAID PATIENT, REFER TO DMS PROV SERVICES MANUAL AND RESUBMIT.
0049	CLAIM/DETAIL DENIED. MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO TOTAL BILLED AMOUNT.
0050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL
0052	ERROR ON CLAIM RELATED TO DOLLAR AMOUNTS -CLAIM IN PROCESS
0053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE.
0054	CLAIM DENIED. OTHER INSURANCE AMOUNT MUST BE MANUALLY COMPUTED FOR THIS CLAIM
0055	CLAIM DENIED TOTAL DETAIL CHARGES NOT EQUAL TO TOTAL BILLED
0056	CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY.
0057	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY
0058	CLAIM/DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL
0059	CLAIM/DETAIL DENIED. NET BILLED CHARGE MISSING OR INVALID
0060	CLAIM DENIED. LOCATION CODE INVALID.
0061	PAID IN FULL BY MEDICAID
0062	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.
0063	CLAIM DENIED. AN 8-DIGIT LONG TERM CARE FACILITY NBR MUST BE ENTERED IN FORM LOCATOR NO.11.
0064	THE TIME OF PICK UP IS BEFORE THE TIME OF CALL IN
0065	DESTINATION CODE IS MISSING/INVALID
0066	PRO STICKER/INDICATOR MISSING OR INVALID
0067	FAMILY PLANNING INDICATOR INVALID
0068	AM/PM PICK-UP INDICATOR MISSING OR INVALID
0069	TIME OF CALL IN MISSING/INVALID
0070	TIME OF PICK UP IS MISSING OR INVALID
0071	DESTINATION CODE MISSING/INVALID
0072	PICK-UP LOCATION CODE MISSING OR INVALID
0073	REFERRED TO (OTHER) CODE INVALID
0074	ANCILLARY CHARGES NOT PAYABLE IN CONJUNCTION WITH VENTILATOR OR BRAIN INJURY PROGRAM REIMBURSEMENT
0075	CLAIM DENIED. QUANTITY DOES NOT MATCH PACKAGE SIZE OR A MULTIPLE OF THE PACKAGE SIZE.
0076	OTHER MEANS OF TRANSPORTATION CODE MISSING OR INVALID
0077	CLAIM DETAIL/DENIED. TIME OF CALL-IN AM/PM INDICATOR MISSING
0078	CLAIM/DETAIL DENIED. BASE RATE OR RATE PER MILE MISSING OR INVALID.
0079	CLAIM/DETAIL DENIED. DETAIL TOTAL BILL NOT EQUAL (RATE PER MILE X EXTRA MILES).
0080	PROVIDER TYPE INVALID FOR CATEGORY OF SERVICE
0081	CLAIM DENIED. NUMBER OF PERSONS SHARING RIDE INVALID.
0082	CLAIM DENIED. TYPE OF TRIP MISSING OR INVALID.
0083	CLAIM DENIED. SECONDARY SURGERY DATE MISSING/INVALID
0084	CLAIM DENIED. PRIMARY SURGERY DATE MISSING/INVALID.
0085	CLAIM DENIED/INVALID LINE ITEM PROVIDER LICENSE NUMBER
0087	CLAIM DENIED. TO DATE OF SERVICE EQUAL TO DATE OF RECEIPT.
0088	CLAIM DENIED. CLAIM INVOICE DATE MISSING/INVALID.
0089	DETAIL CHARGE MISSING OR INVALID
0090	CLAIM DENIED. EPSDT DISPOSITION CODE MISSING OR INVALID.
0091	CLAIM DENIED. YOU MUST INDICATE IN BLOCK 15 IF THIS WAS A PARTIAL, COMPLETE OR COMPLETION OF A PARTIAL EXAM FOR PROCESSING.
0092	THIS SERVICE DENIED. PLEASE RESUBMIT CLAIM WITH COPY OF PATHOLOGY REPORT.
0093	THIS SERVICE DENIED. PLEASE RESUBMIT WITH HISTORY AND PHYSICAL NOTES.
0094	PHYSICIAN SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE
0095	CONSENT FORM IS ILLEGIBLE. RESUBMIT LEGIBLE COPY WITH CLAIM
0096	TREATING PROVIDER NOT ELIGIBLE FOR DATE OF SERVICE
0097	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE

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0098	DIAGNONSIS IS INCORRECT FOR ADULT HEALTH SCREEN (M-MCARE B CLAIM TYPE ONLY)
0099	INITIAL CYCLE OF CLAIM SUBMITTED BY AHCA
0100	DETAIL FROM DATE OF SERVICE MISSING OR INVALID
0101	DETAIL TO DATE OF SERVICE MISSING OR INVALID
0102	LAST DATE OF SERVICE AFTER BILLING DATE
0103	CLAIM HAS BEEN REVIEWED. REFER TO EOB 901-940 FOR DENIAL REASON.
0104	TPL IS INDICATED ON FILE. BUT DID NOT APPEAR ON CLAIM. YOUR CLAIM WAS DENIED AFTER AHCA REVIEW OF THE CLAIM AND ITS ATTACHMENT(S).
0105	DIAGNOSIS IS INCORRECT FOR ADULT HEALTH SCREEN
0106	MULTIPLE VISITS SAME DAY
0107	INCLUDED IN REIMBURSEMENT FOR OFFICE VISIT
0108	CONSENT FORM IS INCOMPLETE
0109	SURG SRV INCLUDES FOLLOW-UP HOSP AND OFFICE VISITS. IF VISIT CLAIM PAYS FIRST SURGERY WILL DENY. VOID VISIT PAYMENT THEN RESUBMIT SURGERY CLAIM.
0110	INVALID COMBINATION OF PROCEDURES OR REVENUE CODES. THIS IS A FATAL EDI EDIT DO NOT RESUBMIT.
0111	BOTH VISIT AND SURGERY NOT COVERED ON SAME DATE OF SERVICE
0112	CLAIM DENIED. DOCUMENTATION ATTACHED WAS INSUFFICIENT TO WAIVE ONE YR FILING LIMITATION. PLEASE CALL AHCA PROVIDER SERVICES FOR ASSISTANCE.
0113	CLAIM DENIED. REQUIRED DOCUMENTATION MISSING/INCOMPLETE.
0114	REQUIRED CONSENT FORM DOCUMENTATION WAS NOT COMPLETED PRIOR TO STERILIZATION PROCEDURE. CLAIM NOT PAYABLE BY MEDICAID.
0115	PAYMENT APPLIED TO RECEIVABLE
0116	DOCUMENTATION OF MEDICAL NECESSITY REQUIRED. CONSULT YOUR PROVIDER MANUAL
0117	CLAIM DENIED. THIS TYPE OF BILL NOT VALID FOR DRG-RELATED CLAIM
0118	ADMIT/DISCHARGE DATE CONFLICT
0119	INVALID NEWBORN OCCURRENCE DATE
0120	LAB PROCESSING CHARGE INCLUDED IN FLAT FEE
0121	MISSING PROVIDER NUMBER
0122	THIS SERVICE WAS NOT APPROVED BY MEDICARE. PLEASE RESUBMIT THIS SERVICE TO MEDICAID WITH A COPY OF THE MEDICARE EOMB.
0123	CLAIM DENIED. THIS CLAIM MAY NOT SPAN THE MEMBERS 1ST BIRTHDAY. PLEASE REFER TO THE BILLING INSTRUCTIONS IN YOUR PROVIDER MANUAL.
0124	INVALID DATE OF SERVICE
0125	THE TOOTH NUMBER IS MISSING OR INVALID
0126	ADMIT/DISCHARGE DATE CONFLICT
0127	LAST DATE OF SERVICE AFTER DATE RECEIVED
0128	THE TOOTH NUMBER IS MISSING OR INVALID
0129	PROVIDER IS NOT ELIGIBLE TO SUBMIT FEE-FOR-SERVICE CLAIMS
0130	CLAIM/DETAIL DENIED. THE DAILY LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.
0131	CLAIM/DETAIL DENIED. CERTAIN TITLE V PROC CODES ARE LIMITED TO A COMBINED TOTAL OF 12 HOURS PER DAY.
0132	TOTAL/SUBMITTED CHARGE MISSING
0133	SUBMITTED CHARGES/TOTAL CLAIM CHARGE CONFLICT
0134	MAP-34 FORM INCOMPLETE
0136	REVENUE CENTER CODE IS MISSING/INVALID
0137	CLAIM DENIED. SERVICES MUST BE BILLED IN CONJUNCTION WITH APPROPRIATE ROOM CHARGES.
0138	TYPE OF BILL IS INVALID
0139	CLAIM/DETAIL DENIED. ASSESSMENTS ARE LIMITED TO 20 UNITS PER CALENDAR YEAR, PER MEMBER.
0140	CLAIM PENDING REVIEW. MEMBER IS A POTENTIAL LOCK-IN MEMBER.
0141	UNITS BILLED ON REVENUE CODES 100-219 DO NOT MATCH COVERED DATE SPANS
0142	CLAIM EXCEEDS 12 MONTH FILING LIMIT
0143	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR PROVIDER TYPE.
0144	SHOULD BE BILLED BY PROVIDER OF SERVICE

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0145	THIS PROCEDURE IS NOT CERTIFIED FOR THIS LABORATORY
0146	HCPC/REVENUE CODE MISSING. PROCEDURE CODE MISSING.
0147	PROCEDURE CODE IS NOT ALLOWED WITH PROVIDER TYPE MODIFIER
0148	THIS PROCEDURE IS NOT APPROPRIATE FOR THIS PLACE OF SERVICE
0149	THIS PROCEDURE/NDC IS NOT APPROPRIATE FOR THE MEMBERS AGE
0150	THIS PROCEDURE IS INVALID FOR THE MEMBERS SEX
0151	CLAIM DENIED. PROCEDURE INVALID FOR DATES OF SERVICE.
0152	PROCEDURE/NDC/REVENUE CODE MISSING OR NOT COVERED BY FLORIDA MEDICAID
0153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
0154	PROCEDURE CODE INVALID FOR PROVIDER TYPE MODIFIER.
0155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR INDIVIDUAL PROVIDER NUMBER IN BILLING FIELD
0156	THE INTERIM RATE FOR THIS PROCEDURE HAS NOT BEEN ESTABLISHED FOR THIS PROVIDER
0157	PROCEDURE CODE INVALID FOR PROVIDER SPECIALTY
0158	CLAIM DENIED DUE TO INJURY DIAGNOSIS
0159	MORE THAN ONE VISIT PER DETAIL DATE OF SERV NOT ALLOWED. EACH VISIT MUST BE BILLED AS SEPARATE LINE ITEMS.
0160	PROCEDURE INVALID FOR TOOTH NUMBER INDICATED
0161	CLAIM DETAIL DENIED. REVENUE CODE INVALID FOR DATE OF SERVICE.
0162	CLAIM DENIED. ANTINEOPLASTIC DRUGS AND CHEMOTHERAPY ADMIN ARE PAYABLE ONLY IF THE DIAGNOSIS IS MALIGNANCY.
0163	DIAGNOSIS CODE MISSING OR INCOMPLETE (OUTPATIENT HOSP: REV CODES 273 OR 279 NOT PAYABLE UNLESS DIAG IS INCLUDED IN RANGE 940.0-949.5)
0164	PRIMARY SURGICAL PROCEDURE CODE MISSING OR NOT ON FILE
0165	INVALID HOSPICE UNITS FOR REVENUE CODE 657
0166	CLAIM/DETAIL DENIED. PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS AGE.
0167	PATIENT STATUS MISSING OR INVALID
0168	PRIMARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX
0169	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR MEMBERS SEX
0170	PLACE OF SERVICE IS INVALID
0171	SECONDARY SURGICAL PROCEDURE CODE INVALID FOR DATE OF SERVICE
0172	PROC CODE MISSING - OUTPATIENT REV CODES IN THE RANGE 300-319 MUST BE ACCOMPANIED BY 5-DIGIT LAB PROC CODE RANGE 80000-89999
0173	ADMISSION DATE/FROM DATE CONFLICT
0174	PROVIDER ON REVIEW FOR PRIMARY SURGICAL PROCEDURE
0175	FIRST SURGERY PROCEDURE CODE IS MISSING
0176	SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW
0177	SECONDARY SURGICAL PROCEDURE CODE INDICATED AS ON REVIEW
0178	FIRST SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION.
0179	TOOTH SURFACE/QUADRANT REQUIRED
0180	INVALID ALPHA TOOTH NUMBER
0181	INVALID TOOTH SURFACE/MOUTH QUADRANT
0182	TOOTH NUMBER/LETTER REQUIRED
0183	RESUBMIT W/HYSTERECTOMY CONSENT FORM ATTACHED
0184	TOTAL/SUBMITTED CHARGE MISSING
0185	ADMISSION DATE OR ACTION CODE ARE MISSING
0186	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY MEMBER
0187	STAMPED SIGNATURES ARE UNACCEPTABLE
0188	CLAIM DENIED. DOCUMENTATION NEEDED FOR CLAIM PROCESSING INCLUDES AUDIOLOGIST RECOMMENDATION, MEDICAL CLEARANCE STATEMENT AND INVOICE.
0189	CONSENT FORM MUST BE SIGNED AND DATED AT LEAST 72 HOURS PRIOR TO STERILIZATION PROCEDURE IN CASES OF EMERGENCY SURGERY OR PREMATURE DELIVERY
0190	THE CLAIM DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.
0191	CALCULATED NUMBER OF DAYS IS NOT EQUAL TO THE NUMBER OF DAYS BILLED

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0192	THIS DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE
0193	MISSING DATE OF SERVICE
0194	DIAGNOSIS IS INVALID FOR MEMBERS SEX
0195	THE SECONDARY DIAGONISIS IS INVALID FOR MEMBER SEX
0196	THE BILLED DIAGNOSIS IS ON REVIEW
0197	CLAIM/DETAIL DENIED. ROOT CANAL THERAPY LIMITED TO PERMANENT TEETH.
0198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH
0199	THIRD SURGERY DATE (FIELD 81) NOT WITHIN STATEMENT COVERS PERIOD - DATE SPAN (FIELD 6)
0200	CLAIM/DETAIL DENIED. PROVIDER ON REVIEW FOR THIS DIAGNOSIS
0201	INDIVIDUAL/CLINIC PROVIDER/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
0202	DIAGNOSIS CODE NOT COVERED FOR BIRTH CENTER PROCEDURE CODE
0203	CLAIM/DETAIL DENIED. PROCEDURE CODE MODIFIER AG OR TYPE OF SERVICE 7 OR B NOT ALLOWED FOR DATES OF SERVICE AFTER 12/12/94.
0204	INVALID DIAGNOSIS CODE. CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.
0205	DIAGNOSIS CODE INVALID FOR PROVIDER TYPE
0206	CLAIM DENIED. RENDERING PROVIDER IS NOT ELIGIBLE FOR THE DATE OF SERVICE.
0207	A SURGICAL PROCEDURE (WITHOUT A MODIFIER) IS BILLED WITHIN THE FOLLOW-UP OF A PREVIOUS SURGICAL PROCEDURE
0208	THIS PROCEDURE IS NOT COVERED FOR THIS DIAGNOSIS
0209	CLAIM DENIED. MOST ANESTHESIA SERVICES MUST BE BILLED USING ANESTHESIA PROCEDURE CODES BEGINING WITH 0.
0210	CLAIM/DETAIL DENIED. THIRD HEADER DIAGNOSIS ON REVIEW.
0211	CLAIM/DETAIL DENIED. THIRD DIAGNOSIS IS NOT ON FILE.
0212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.
0213	THE FOURTH DIAGNOSIS IS MISSING OR INVALID. PLEASE ENTER THE APPROPRIATE DIAGNOSIS CODE AND RESUBMIT THE CLAIM.
0214	CLAIM/DETAIL DENIED. SECONDARY HEADER DIAGNOSIS ON REVIEW.
0215	CLAIM DENIED - AGE RESTRICTION FOR COVERED DIAGNOSIS
0216	SERVICE DATE IS AFTER THE RECIPIENTS DATE OF DEATH
0217	THE FOURTH DIAGNOSIS IS NOT COVERED FOR THE MEMBERS AGE
0218	FOURTH DIAGNOSIS IS INVALID FOR MEMBERS SEX
0219	FOURTH HEADER DIAGNOSIS ON REVIEW
0220	CPHU ENCOUNTER LIMIT - CANNOT BILL MULTIPLE CPHU ENCOUNTERS FOR THE SAME SERVICE DATE
0221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
0222	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE
0223	THIS SERV CANNOT BE BILLED WITH A DATE SPAN THAT INCLUDES 2 OR MORE MONTHS. REBILL WITH ONE MONTH OF SERVICES PER CLAIM LINE.
0224	PARTIAL APPROVAL (MO) DATES ARE NOT WITHIN ADMIT/DISCHARGE DATES
0225	NO HISTORY MATCH FOUND, PLEASE RESUBMIT
0226	INVALID CONDITION CODE
0227	PATIENT STATUS MISSING OR INVALID
0228	THE PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE
0229	BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE
0230	THERAPY NOT COVERED FOR RECIPIENT 21 YEARS OF AGE OR OLDER
0231	INVALID R.A.P. REFERRING PROVIDER NUMBER
0232	CLAIM/DETAIL DENIED. ACTION REASON CODE INDICATES PROVIDER IS ON REVIEW.
0233	RECIPIENT HAS OTHER INSURANCE COVERAGE ON MEDICAID 3RD PARTY LIABILITY FILE. PLEASE FILE WITH OTHER CARRIER OR ATTACH INSURANCE COMPANY DENIAL.
0234	CLAIM/DETAIL DENIED. REFERRING PROVIDER FLAG SET TO SUSPEND FOR REVIEW.
0235	SURGERY DATE IS BEFORE THE ADMIT DATE
0236	SURGERY DATE AFTER BILLING DATE
0237	CLAIM DENIED. CLINIC PROVIDER NUMBER NOT ON FILE
0238	CLAIM DENIED. BILLING PHYSICIAN/PROVIDER NOT LISTED AS MEMBER OF CLINIC.

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0239	DETAIL PROVIDER NUMBER INVALID OR NOT ON FILE
0240	PROCEDURE CANNOT BE BILLED INDEPENDENTLY
0241	PENDING CONFIRMATION OF PROVIDER ELIGIBILITY
0242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26
0243	PROCEDURE CODE Y2870 INVALID FOR DATES OF SERVICE 10/15/94 AND AFTER FOR THIS PROVIDER TYPE
0244	PROVIDER HAS NOT MET ALL REQUIREMENTS FOR BILLING OTHER LAB AND X-RAY SERVICES
0245	SVC DATES NOT ELIGIBLE
0246	80022-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF NOT ALLOWED SAME DOS/MEMBER/PROVIDER AS 80020-BLOOD COLLECTION VENIPUNCTURE
0247	PHYSICIAN ASSISTANT NUMBER MISSING/INVALID, NOT ELIG FOR THE DOS OR NOT LINKED TO AN INDIVIDUAL PHYSICIAN
0248	CLAIM DENIED. SURGEON AND ASSISTANT SURGEON BILLING NOT ALLOWED ON SAME FORM.
0249	PAYMENT REDUCED BECAUSE OUR RECORDS SHOW MEMBER WAS NOT IN FACILITY FOR ALL OF THE TOTAL BILLED DAYS
0250	RECIPIENT ID NOT ON FILE. BECAUSE UPDATE MAY ARRIVE FROM AHCA RECIPIENT. FILE RECHECKED WEEKLY FOR A MATCH. IF NUMBER INCORRECT, RESUBMIT NOW.
0251	INCORRECT MEMBER IDENTIFICATION NUMBER
0252	RECIPIENT IS NOT ACTIVE
0253	RECIPIENT INELIGIBLE FOR DOS WILL PEND FOR UP TO 14 DAYS AWAITING AHCA UPDATE RECIPIENT ELIG RECHECKED WEEKLY FOR ARRIVAL OF AHCA UPDATE
0254	THE MEMBER IS NOT ELIGIBLE ON THE CLAIM SERVICE DATES
0255	MEMBER HAS MEDICARE PART B. PLEASE BILL MEDICARE FOR THESE SUPPLIES
0256	OUR RECORDS INDICATE THAT THIS MEMBER MAY BE ELIG FOR MEDICARE. PLEASE BILL MEDICARE FIRST. IF MEDICARE DENIES THIS SERVICE, RESUBMIT WITH PROOF OF DENAL.
0257	OUR RECORDS INDICATE THAT THE MEMBER WAS OVER 21 YRS OLD ON THE DATE(S) OF SERVICE. THE MEMBER IS NOT ELIGIBLE FOR THE SERVICE(S)
0258	RECIPIENT ID NOT ON FILE. AN UPDATE MAY ARRIVE FROM AHCA. RECIPIENT FILE IS CHECKED WEEKLY FOR A MATCH. IF NUMBER INCORRECT, RESUBMIT NOW.
0259	DATE BILLED INVALID
0260	SERVICE NOT ALLOWED
0261	OUR RECORDS INDICATE THAT THE MEMBER WAS DECEASED PRIOR TO THE ENDING DATE OF SERVICE
0262	PROVIDER TYPE NOT ON TPL MATRIX
0263	CLAIM DENIED. MEMBER NOT ELIGIBLE FOR PORTION OF DATES OF SERVICE
0264	MEMBER NAME IS MISSING
0265	INCORRECT MEMBER IDENTIFICATION NUMBER
0266	MEMBER NOT ELIGIBLE FOR WAIVER SERVICES
0267	WAIVER PAYMENT AMOUNT REDUCED DUE TO MEMBER CONTINUING INCOME
0268	MEMBER ON REVIEW
0269	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS ENROLLED IN A WAIVER OR HOSPICE PROGRAM.
0270	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR A MODEL WAIVER MEMBER.
0271	RECIPIENT INELIGIBLE FOR DOS. CLAIM WILL PEND FOR UP TO 14 DAYS AWAITING AHCA UPDATE. RECIPIENT ELIGIBLE RECHECKED WEEKLY FOR ARRIVAL OF AHCA UPDATE
0272	CLAIM/DETAIL DENIED. UNIT BILLED AMOUNT CANNOT BE GREATER THAN.
0273	RECIPIENT IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE
0274	SERVICE DATE IS AFTER THE RECIPIENTS DATE OF DEATH.
0275	INPATIENT HOSPITAL TREATMENT AUTHORIZATION NUMBER MISSING OR INVALID
0276	SOBRA - CLAIM REQUIRES MEDICAL REVIEW
0277	THE ATTACHED THIRD PARTY DOCUMENTATION IS NOT SUFFICIENT. CONTACT UNISYS PROVIDER RELATIONS FOR ASSISTANCE.
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PYMNT WAS RECEIVED BY MEMBER.

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0279	ALIEN - CLAIM REQUIRES MEDICAL REVIEW. IF YOU DID NOT ATTACH MEDICAL TO THIS SUBMISSION, PLEASE DO SO AND RESUBMIT.
0280	CLAIM DENIED. YOUR CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY. PLEASE BILL OTHER INSURANCE FIRST.
0281	ABORTION PROC OR CONDITION CODE A7 OR A8 IS PRESENT AND NO ABORTION CERTIFICATE IS PRESENT
0282	THE MEMBER HAS MEDICARE PART A PLEASE BILL MEDICARE
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B: PLEASE BILL MEDICARE
0284	OUR RECORDS INDICATE THAT THIS MEMBER IS ELIGIBLE FOR HOSPICE COVERAGE BY MEDICARE. PLEASE BILL MEDICARE FIRST.
0285	RECIPIENT INELIGIBLE FOR DOS WILL PEND UP TO 14 DAYS AWAITING AHCA UPDATE. RECIPIENT ELIGIBLE RECHECKED WEEKLY FOR ARRIVAL OF AHCA UPDATE.
0286	THIS PROCEDURE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DATE OF SERVICE
0287	PROFESSIONAL COMPONENT REV CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL COMPONENT REVENUE CODE
0288	PROFESSIONAL COMPONENT REV CODE MUST BE BILLED WITH CORRESPONDING TECHNICAL REV CODE. CHARGES MOVED TO NON-COVERED.
0289	CLAIM DENIED. RENDERING PROVIDER NUMBER MISSING OR INVALID.
0290	PENDING CONFIRMATION OF MEMBER ELIGIBILITY
0291	PENDING POSSIBLE OTHER INSURANCE INVOLVEMENT
0292	CLAIM SUSPENDED FOR BUY-IN ELIGIBILITY REVIEW
0293	CLAIM SUSPENDED FOR ELIGIBILITY REVIEW
0295	BILLING OR REFERRING PROVIDER NUMBER IS MISSING
0296	PAY TO PROVIDER INELIGIBLE FOR DATE(S) OF SERVICE
0297	PAY TO PROVIDERS GROUP IS NOT VALID FOR THE TREATING PROVIDER
0298	MEMBER IS NOT ELIGIBLE FOR HOSPICE FOR BILLED DATES OF SERVICE
0299	HOSPICE MEMBER. OUR FILES SHOW MEMBER IS COVERED BY ANOTHER HOSPICE PROVIDER FOR BILLED DATE(S) OF SERVICE.
0300	TREATING PROVIDER NUMBER NOT ON FILE
0301	CLAIM DENIED. RENDERING PROVIDER NOT LISTED AS A MEMBER OF THE BILLING GROUP.
0302	DPR NUMBER IS NOT FOUND ON FILE
0303	THIS SERVICE MUST BE BILLED FOR A MINIMUM OF 8 UNITS PER DATE OF SERVICE
0304	PARTIAL APPROVAL (MO) DATES ARE NOT WITHIN ADMIT\DISCHARGE DATES
0305	TREATING PROVIDERS CLAIM DENIED AFTER DEPT OF HEALTH AND REHAB SRVS REVIEW
0306	A HOSPICE MEMBER - RECYCLE FOR EDIT 298
0307	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER
0308	INVALID DATE OF SERVICE
0309	BILLING PROVIDER IS UNDER REVIEW
0310	CLAIM DENIED. NEW ADMISSION NOT PAYABLE BECAUSE OF NON-COMPLIANCE.
0311	CORRECTED PAYMENT PER ADJUSTMENT REQUEST
0312	PHYSICIANS-REFER PROV REQD FOR THIS PROC IN FIELD 17A/19. THERAPISTS, HOME HEALTH AND DME SUPPLIERS: SVC REQUIRES A SVC AUTH IN FIELD 17A/19.
0313	SPECIAL PROGRAM INDICATOR FIELD - ONLY VALID ENTRY IS (04) FOR FAMILY. LEAVE THIS FIELD BLANK UNLESS FAMILY PLANNING APPLICABLE.
0314	ASSISTIVE CARE SERVICE CLAIMS CANNOT SPAN MORE THAN ONE MONTH. PLEASE CHECK THE DATES OF SERVICE AND RESUBMIT THE CORRECTED CLAIM.
0315	TPL ON CLAIM, NOT ON RECIPIENT FILE
0316	CLAIM/DETAIL PAID. CLAIMS HISTORY REFLECTS THE TOOTH NUMBER PREVIOUSLY EXTRACTED. PLEASE CHECK RECORDS AND VERIFY TOOTH NUMBER.
0317	UNITS BILLED ON REVENUE CODES 100-219 DO NOT MATCH COVERED DATE SPANS
0318	MANUAL PRICE-REQUIRES REPORT
0319	INCORRECT PROVIDER NUMBER SUBMITTED - PAYMENT DELAYED
0320	CLAIM DENIED. EXCEEDS THERAPY LIMITS FOR DRUG CLASS.
0321	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE
0322	EPSDT RELATED PROC ARE NOT PAYABLE WITHIN 30 DAYS OF AN EPSDT SCREENING PROC

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0324	DIAGNOSIS INCOMPATIBLE WITH RECIPIENTS SEX
0325	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBERS AGE
0326	CLAIM DENIED. BILL/INVOICE MUST ACCOMPANY CLAIM.
0327	PROCEDURE/NDC REQUIRES PRIOR AUTHORIZATION
0328	PRIMARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION
0329	SECONDARY SURGICAL PROCEDURE REQUIRES PRIOR AUTHORIZATION
0330	DETAIL DENIED. DETAIL UNITS BILLED EXCEED UNITS PRIOR AUTHORIZED
0331	PAYMENT REDUCED BY AMOUNT PREVIOUSLY PAID. POST OP INCLUDED IN PROCEDURE.
0332	MISSING OR INVALID AHCA ELIGIBILITY FORM FOR MEDICALLY NEEDY. PHOTOCOPIED FORM 2902 MUST CONTAIN DENIAL TCN IN TOP RIGHT WHEN RESUBMITTING
0333	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS REQUIRE PRIOR AUTHORIZATION
0334	SUPPLY NOT COVERED ON RENTAL ITEM
0335	LACKS REPORT TO JUSTIFY HIGHER FEE
0336	INVALID PATIENT RESPONSIBILITY
0337	CATHETERIZATION PROC 8002, 80023 AND 80024 NOT ALLOWED SAME DOS/MEMBER/PROV
0338	FINANCIAL CLASS/PATIENT RESPONSIBILITY MISMATCH
0339	INSURANCE CODE 04 HAS BEEN SUBMITTED WITH THE CLAIM
0340	ONLY THREE FOLLOW UP EXAMS ALLOWED DURING THE SIX MONTH PERIOD FOLLOWING THE FITTING OF A HEARING AID
0341	AN OFFICE VISIT, ER VISIT OR CONSULTATION ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS A HOSPITAL ADMISSION
0342	OFFICE VISIT AND/OR ER VISIT ARE NOT PAYABLE ON THE SAME DOS AS A CONSULTATION
0343	CLAIM MASS ADJUSTED DUE TO A RETROACTIVE RATE CHANGE
0344	AN OFFICE VISIT IS NOT PAYABLE ON THE SAME DOS AS AN EMERG ROOM VISIT
0345	80020-BLOOD COLLECTION VENIPUNCTURE NOT ALLOWED SAME DOS/MEMBER/PROVIDER AS 800 22-ROUTINE VENIPUNCTURE SINGLE HOMEBOUND NURSING HOME OR SNF.
0346	INVALID NUMBER OF DAYS COVERED
0347	DENTURE RELATED EMERGENCY SERVICES AND UPPER OR LOWER DENTURE RELINE NOT PAYABLE ON SAME DATE OF SERVICE.
0348	ROOM CHARGES REDUCED TO SEMI PRIVATE RATE
0349	EMERGENCY DENTAL PROCEDURES AND EXTRACTION PROCEDURES NOT PAYABLE ON SDOS
0350	DETAIL DENIED. FILLINGS ARE NOT PAYABLE FOR THE SAME TOOTH AND THE SAME DOS SERVICE AS EMERGENCY SERVICES OR SEALANTS.
0351	ALLOW TO SUB PERCENT DIFF EX
0352	SUB TO ALLOW PERCENT DIFF EX
0353	INDIVIDUAL ALLERGY TESTING PROCEDURES ARE NOT PAYABLE WITH W0308-MAXIMUM ALLOWABLE PER ALLERGY TESTING OF SERVICE
0354	MANUAL PRICE INVALID OR NOT ACCOMPANIED BY A MANUAL PRICE EOB
0355	FEE ADJUSTED TO MAXIMUM ALLOWABLE AMOUNT
0356	CLAIM/DETAIL DENIED AFTER REVIEW BY MEDICAL CONSULTANTS
0357	CLAIM DENIED. INVOICE MUST HAVE ITEM BILLED NOTED.
0358	TREATING PROVIDER/REFERRING PROVIDER NUMBER ARE EQUAL
0359	REFER TO THE ADJUSTMENT REASON CODE
0360	FEE ADJUSTED PER CLAIM CREDIT
0361	PROCEDURE CODE NOT ON FILE
0362	MEDICARE DEDUCTIBLE GREATER THAN ALLOWED DEDUCTIBLE
0363	ROOT REMOVAL NOT PAYABLE ON SAME DATE OF SERVICE AS THE TOOTH EXTRACTION
0364	PAYMENT REDUCED BY OTHER INSURANCE
0365	FEE ADJUSTED TO MAXIMUM ALLOWABLE
0366	CLAIM DENIED. BILLED AMOUNT MAY NOT EXCEED \$50.00 PER UNIT OF SERVICE
0367	THIS SERVICE PAID COINSURANCE AND/OR DEDUCTIBLE
0368	PROVIDER IS NOT ELIGIBLE TO BILL FOR HOME HEALTH SUPPLIES AND/OR VISITS
0369	ORIGINAL PSYCHIATRIC EVALUATION AND REGULAR HOSPITAL ADMISSION NOT PAYABLE ON SAME DATE OF SERVICE
0370	PAYMENT MODE NOT FOUND FOR BILLING PROVIDER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0371	REIMBURSEMENT RATE NOT FOUND FOR DATE OF SERVICE
0372	HOSPITAL FOLLOW-UP VISITS AND ORIGINAL PSYCHIATRIC DIAGNOSTIC EVAL AND/OR FOLLOW-UP PSYCHIATRIC CARE ARE NOT ALLOWED FOR SAME DATE OF SERVICE
0373	UNITS OF SERVICE HAVE BEEN REDUCED TO THE REMAINING PRIOR AUTHORIZED QUANTITY
0374	REPAYMENT PORTION OF THIS ADJUSTMENT HAS BEEN DENIED. RECOUPMENT IS UNDER FINANCIAL ITEMS.
0376	CLAIM DENIED. MAC FIELD INVALID.
0377	MEMBER INCOME/PATIENT LIABILITY DEDUCTION NOT APPLICABLE FOR THIS CLAIM
0378	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED.
0379	PAID BY MEDICAID
0380	CO-PAY WAS DEDUCTED FROM REIMBURSEMENT
0381	CERTAIN SPECIFIED PROCEDURES ARE NOT REIMBURSABLE FOR SAME DATE OF SERV AS EMERGENCY ROOM VISIT
0382	DETAIL DENIED. BILLED AMOUNT FOR IMPLANTABLES MUST BE GREATER THAN \$100.00.
0383	CERTAIN INCIDENTAL SURGERIES ARE NOT REIMBURSABLE FOR SAME DATE OF SERV AS ABDOMINAL SURGERY
0384	DETAIL DENIED. INVOICE MUST BE ATTACHED WHEN BILLING IMPLANTABLES.
0385	CERTAIN INCIDENTAL PROCEDURES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE AS A D AND C PROCEDURE
0386	DETAIL DENIED. INVOICE AMOUNT MUST MATCH BILLED AMOUNT.
0387	CERTAIN INCIDENTAL SURGERIES AND PELVIC SURGERIES ARE NOT REIMBURSABLE FOR THE SAME DATE OF SERVICE
0388	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ANCILLARY REVENUE CODE (240). CHARGES MOVED TO NON-COVERED.
0389	PAID CLAIM BASED UPON MEDICAL REVIEW
0390	CLAIM DENIED. DUPLICATE SERVICE BILLED
0391	DETAIL DENIED. PROCEDURE CODES X0091/97535 AND X0103/S5140 NOT PAYABLE ON SAME DATE OF SERVICE AS X0061/T2016, X0088/S5126 OR X0089/H0043.
0392	DETAIL DENIED. PROCEDURE CODES X0061, X0088 AND X0089 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0091
0393	CLAIM DENIED. THE PRIMARY DIAGNOSIS CODE IS NOT VALID FOR THIS PROVIDER TYPE.
0394	HOURLY RESPITE SERV NOT ALLOWED FOR SAME DATE OF SERVICE AS DAILY RESPITE SERV
0395	AMOUNT PD BY OTHER INSURANCE EQUALS OR EXCEEDS AMOUNT OF MEDICAID REIMBURSEMENT FOR THIS SERV THE CLM IS PD IN FULL
0396	DAILY RESPITE SERVICES NOT ALLOWED FOR SAME DOS AS HOURLY RESPITE S
0397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM
0398	CLAIM/DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
0399	CLAIM/DETAIL DENIED. THIS SERVICE NOT COVERED FOR THIS MEMBER.
0400	INVALID MODIFIER FOR ARNP. REGISTERED NURSE ANESTHETISTS CAN PROVIDE ONLY ANESTHESIA SERVICES - MODIFIER 48 NOT VALID.
0401	ELECTRONIC ADJUSTMENT/VOID CLAIM TYPES DO NOT MATCH
0402	A CLAIM FOR INPATIENT SERVICES COVERS MORE THAN 15 DAYS, THE RECIPIENT IS LESS THAN 21 YEARS OLD AND THE DIAGNOSIS CODE IS 290.00-316.99
0403	PLEASE GIVE THE DATE(S) OF SURGERY AND RETURN THE INVOICE TO THIS OFFICE
0404	NURSING FACILITY PRIOR AUTHORIZATION NOT ON FILE - RECYCLE FOR EDIT 332
0405	ADJUSTMENT EXCEEDS 12 MONTHS FROM DATE. SEE PROVIDER MANUAL FOR EXCEPTION CRITERIA
0406	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO
0407	PLACE OF SERVICE IS MISSING
0408	INVALID OR SPANNED HEADER DATES - OUTPATIENT BILLS MUST CONTAIN A SINGLE DATE OF SERVICE
0409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM
0410	FORMAT INVALID FOR ELECTRONIC CLAIMS.
0411	DUE TO THE END OF YOUR FISCAL YEAR, PLEASE REBILL THESE MULTIPLE MONTHS OF SERVICE ON SEPARATE INVOICES - ONE INVOICE FOR EACH MONTH.
0412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0413	MEMBER NOT ENROLLED IN MANAGED CARE DURING DATES OF SERVICE
0414	MEMBER ENROLLED IN MANAGED CARE DURING DATES OF SERVICE
0415	FFS CLAIM HAS A MANAGED CARE PROVIDER TYPE
0416	CAPITATION RATE NOT WITHIN DATES OF SERVICE
0417	CLAIM DENIED. INVALID OR MISSING CAPITATION INDICATOR.
0418	CLAIM DENIED. INVALID ENCOUNTER TYPE.
0419	INDEPENDENT LABORATORY - INVALID PLACE OF SERVICE
0420	CLAIM DENIED. INVALID ENC PAYMENT AMOUNT.
0421	CLAIM DENIED. INVALID ENC PAYMENT DATE.
0422	CLAIM DENIED. INVALID ENC ADJUSTMENT TCN.
0423	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR PHYSICAL.
0424	CLAIM DENIED. INVALID MEMBER NOT ELIG FOR BEHAVIORAL.
0425	DATE SPAN BILLING NOT ALLOWED FOR THIS PROC CODE. BILL EACH DATE OF SERV ON A SEPARATE CLAIM LINE.
0426	THE 36 MONTH MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE
0427	CLAIM DENIED. RESUBMIT AN ADJUSTMENT ON RELATED PAID CLAIM WITH JUSTIFICATION FOR DUPLICATED SERVICE.
0428	FFS NOT ALLOWED, MEMBER ELIGIBLE FOR BEHAVIORAL HEALTH MANAGED CARE
0429	CLAIM DENIED. PARTNERSHIP NUM MISMATCH
0430	CLAIM DENIED. ENCOUNTER, INVALID TCN TO CREDIT
0431	RESERVED FOR MANAGED CARE
0432	CLAIM DENIED. SEQ NO. MISMATCH ACROSS CLAIM.
0433	CLAIM DENIED. VOID/RESUB INVALID FOR XOVER.
0434	RESERVED FOR MANAGED CARE
0435	RESERVED FOR MANAGED CARE
0436	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS LIMITED TO 1 UNIT PER MEMBER, PER FIVE YEARS.
0437	CLAIM DENIED. CERTAIN OUTPATIENT HOSPITAL CHARGES ARE NOT PAYABLE WITHIN 3 DAYS PRIOR TO AN INPATIENT HOSPITAL ADMISSION AND VICE VERSA.
0438	CLAIM DETAIL DENIED. PROCEDURE CODE 90853 IS LIMITED TO 6 UNITS PER DAY, PER MEMBER, PER PROVIDER.
0439	INVALID RECIPIENT ID NUMBER
0440	CLAIM/DETAIL DENIED. REVENUE CODE 582 LIMITED TO 4 UNITS PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY).
0441	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE LIMITED CUMULATIVELY TO ONE UNIT PER DAY PER MEMBER.
0442	CLAIM/DETAIL DENIED. THIS PROCEDURE CODES IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS PROCEDURE CODES 99244 AND 99245.
0443	CLAIM/DETAIL DENIED. PROCEDURE CODES 99244 AND 99245 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE AS CERTAIN OTHER TITLE V PROCEDURE CODES.
0444	PLEASE CORRECT INVALID OR MISSING NDC NUMBER
0445	CLAIM/DETAIL DENIED. PROCEDURE CODE 99244 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.
0446	CLAIM/DETAIL DENIED. PROCEDURE CODE 99245 IS LIMITED TO ONE PER FIVE YEARS, PER MEMBER, PER PROVIDER.
0447	CLAIM/DETAIL DENIED. X0079 LIMITED TO 8 UNITS PER DAY.
0448	MEMBER NOT ON ELIGIBILITY FILE - SUSPEND FOR EDIT 250
0449	THE MEMBER ELIGIBILITY NUMBER ON THE MEDICAID CARD ATTACHED WITH YOUR CLAIM IS INCORRECT.
0450	MOUTH QUADRANT REQUIRED
0451	CLAIM DETAIL DENIED. UNABLE TO APPLY ASSESSMENT PROC LIMITATION DUE TO NO CASE MANAGEMENT ON PRIOR AUTHORIZATION FILE.
0452	CLAIM/DETAIL DENIED. X0080/H0004 LIMITED TO 12 UNITS PER WEEK.
0453	CLAIM/DETAIL DENIED. X0061/T2016, X0088/S5126, X0089/H0043 AND X0103/S5140 LIMITED TO 1 UNIT, CUMULATIVELY, PER DAY.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0454	CLAIM/DETAIL DENIED. X0079/H0039 LIMITED TO 32 UNITS PER DAY.
0455	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 48 UNITS PER DAY.
0456	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
0457	CLAIM/DETAIL DENIED. X0100/H0043 AND X0101/T2016 LIMITED TO ONE UNIT, CUMULATIVELY, PER DAY.
0458	CLAIM/DETAIL DENIED. RESPITE SERVICES ARE LIMITED TO \$150.00 PER DAY.
0459	CLAIM/DETAIL DENIED. PROCEDURES WITH GT MODIFIER ARE LIMITED TO FOUR (4) PER CALENDAR YEAR.
0460	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 16 UNITS PER DAY.
0461	CLAIM/DETAIL DENIED. XL307/97535 LIMITED TO 80 UNITS PER WEEK.
0462	PROVIDER TYPE/CLAIM TYPE NOT FOUND ON MATRIX
0463	OCCURRENCE SPAN FROM DATE IS GREATER THAN THE OCCURRENCE SPAN TO DATE
0464	PAY AND BILL TPL CLAIM
0465	MEMBER COVERED BY PRIVATE INSURANCE (NO ATTACHMENT)
0466	DETAIL DENIED. EARLY INTERVENTION AND CERTAIN EPSDT-SPECIAL SERVICES PROCEDURES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER.
0467	MEMBER HAS OTHER MEDICAL COVERAGE. BILL OTHER INSURANCE FIRST OR ATTACH DOCUMENTATION OF DENIAL FROM THE INSURANCE CARRIER.
0468	837D CROSSOVER DENTAL CLAIM
0469	CLAIM/DETAIL DENIED. COMPANION CARE UNITS ARE LIMITED TO 200 PER WEEK.
0470	THE UNITS OF SERVICE BILLED WAS NOT WITHIN THE SPECIFIED RANGE ALLOWED
0471	RECIPIENT IS NOT ELIGIBLE FOR MEDICAID SERVICES, BUT MAY BE ELIGIBLE FOR MEDICARE. MEDICAID PRESCRIPTION SERVICES NOT COVERED.
0472	MEMBERS LIMITED TO ONE DRUG CLASS (GPPC) 681200 PRSCRIPTION/REFILL PER DOS
0473	MEDICAID REIMBURSEMENT FOR THIS DOS HAS ALREADY BEEN MADE. CLAIM PAYMENT SET TO ZERO
0475	ENCOUNTER PAY TO NOT WITHIN SUBMITTER PROVIDER NETWORK
0476	MEMBER IN AN INSTITUTIONAL SETTING DURING THE SAME DATE OF SERVICE
0477	MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATES OF SERVICE
0478	YOUR FACILITY HAS PREVIOUSLY BILLED AND RECEIVED PAYMENT FOR ALL OR A PORTION OF THESE DATES OF SERVICE
0479	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER
0480	PAY TO PROVIDER NOT AUTHORIZED FOR DIRECT PAYMENT. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTIONS.
0481	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
0483	DUPLICATE ANESTHESIA SERVICE BILLED BY PHYSICIAN AND NURSE ANESTHETIST
0484	ONLY ONE ANESTHESIA ALLOWED PER DOS PER MEMBER
0485	PAPER ATTACHMENT NOT RECEIVED WITHIN 21 DAYS
0486	DETAIL PLACE OF SERVICE NOT COVERED THROUGH THE PODIATRY PROGRAM
0487	ROUTINE FOOT CARE IS NOT PAYABLE FOR THIS DIAGNOSIS
0488	ABORTION CERTIFICATION MISSING
0489	CLAIM DENIED. THIS SERVICE WAS PREVIOUSLY PAID TO ANOTHER PROVIDER.
0490	CONSECUTIVE OUTPATIENT SERVICES ARE NON-PAYABLE DURING A HOSPITAL INPATIENT STAY.
0491	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DOS
0492	CLAIM HAS BEEN REVIEWED. REFER TO EOB CODES 901 - 940 FOR DENIAL REASON.
0493	CLAIM/DETAIL DENIED. DCBS MEMBERS MAY NOT RECEIVE THE SAME DCBS MENTAL HEALTH SERVICES FROM TWO DIFFERENT SUB-PROVIDERS ON THE SAME DATE OF SERVICE.
0494	DETAIL DENIED. THIS SERVICE IS NOT PAYABLE BEYOND THE BIRTH MONTH OF THE MEMBERS 18TH BIRTHDAY.
0495	INVALID HOSPICE REVENUE CODE OR INVALID COMBINATION OF HOSPICE REVENUE
0496	ONLY ONE (1) ANESTHESIA\IV SEDATION ALLOWED PER DATE OF SERVICE PER MEMBER
0497	CLAIM/DENIED. RESUBMIT AN ADJUSTMENT ON UNISYS ADJUSTMENT REQUEST FORM.
0498	CLAIM DENIED. ONLY ONE PAYMENT ALLOWED PER MEMBER, PER DATE OF SERVICE.
0499	CLAIM PENDING REVIEW OF HISTORY

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0500	BIFOCAL OR SINGLE VISION LENSES LIMITED TO TWO SETS PER 12 MONTHS.
0501	PROFESSIONAL FEE-DISPENSING SERVICE ALLOWED ONE PER 12 MONTHS PER MEMBER
0502	ONE FAMILY PLANNING SERVICE PER DOS
0503	ANNUAL FAMILY PLANNING VISITS LIMITED TO 1 PER MEMBER PER NINE MONTHS PER CLINIC
0504	FAMILY PLANNING MEMBERS LIMITED TO ONE INITIAL VISIT PER PROVIDER PER THREE YEAR PERIOD
0505	MEMBER IN INSTITUTIONAL SETTING DURING SAME DATE OF SERVICE
0506	BILLED DATE GREATER THAN BATCH DATE
0507	PACKAGE OF 12 TESTS AND COMPONENTS NOT ALLOWED SAME DOS
0508	COMPLETE BLOOD COUNT AND COMPONENTS NOT ALLOWED SAME DOS
0509	MEMBERS ARE LIMITED ON INITIAL AND FOLLOW UP VISITS TO ONE PER YEAR, PER PROVIDER FOR DOS PRIOR TO SEPT 1, 1985
0510	RECIPIENT LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DOS
0511	PAYMENT FOR REVISION OF ARTERIOVENOUS SHUNT IS INCLUDED IN FEE FOR INITIAL INSERTION WHEN REVISION IS PERFORMED WITHIN 21 DAYS OF ORIGINAL PROCEDURE.
0512	CLAIM DENIED. FOLLOW UP VISIT INCLUDED IN REIMBURSEMENT FOR DELIVERY.
0513	FOLLOW-UP HOSPITAL VISITS INCLUDED IN REIMBURSEMENT FOR C-SECTION.
0514	CAST APPLICATION/REMOVAL INCLUDED IN REIMBURSEMENT FOR SURGERY
0515	CLAIM DENIED. CULTURES/SMEARS NOT ALLOWED SAME DOS FOR SAME CONDITION.
0516	EXTRACTION OR EXPOSURE OF TOOTH DISALLOWED IF PREVIOUSLY EXTRACTED OR EXPOSED
0517	CLAIM DENIED. EMERGENCY SERVICES LIMITED TO ONE PER DOS PER MEMBER PER PROVIDER.
0518	CLAIM/DETAIL DENIED. INITIAL TOOTH EXTRACTION LIMITED TO ONE PER DOS/MEMBER/PROVIDER. USE PROCEDURE 07120 FOR EACH ADDITIONAL TOOTH EXTRACTED
0519	CLAIM DENIED. REIMBURSEMENT FOR CIRCUMCISION WITHIN TEN DAYS OF DELIVERY IS INCLUDED IN DELIVERY FEE.
0520	MAINTENANCE DRUG DAYS SUPPLY LESS THAN 30 DAYS
0521	COMPREHENSIVE CLIENT RE-EVALUATION NOT ALLOWED WITHIN 12 MONTHS OF COMPREHENSIVE CLIENT EVALUATION.
0522	COMPREHENSIVE CLIENT RE-EVALUATION LIMITED TO ONCE PER LIFE TIME
0523	RESIDENTIAL COMPONENT SERV NOT ALLOWED WITH IN-HOME SCL SERVICES ON SAME DOS
0524	MOTHER DISCHARGE DATE IS ZERO
0525	INPATIENT MEMBERS ARE LIMITED TO ONE ATTENDANCE AND ONE CONSULTATION PER ADMISSION
0526	INPATIENT MEMBERS WHO HAVE HAD ORAL SURGERY ARE LIMITED TO ONE ATTENDANCE AND/OR ONE CONSULTATION PER DATE OF SERVICE PER PROVIDER
0527	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED IF THE TOOTH HAS BEEN PREVIOUSLY EXTRACTED
0528	ADDITIONAL SERVICES TO THE SAME TOOTH ARE DISALLOWED ON THE SAME DOS AS A CROWN PROCEDURE OR A FRACTURED INCISAL BUILD-UP
0529	CROWN AND BUILD UP PROCEDURES ARE DISALLOWED IF ADDITIONAL DENTAL SERVICES HAVE BEEN PAID FOR THE SAME TOOTH SAME DOS
0530	CLAIM PAID. CLAIM HAS BEEN REDUCED BY THE AMOUNT OF THE DISPENSING FEE.
0531	PURCHASE UNITS BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM
0532	RENTAL UNITS/CHARGES BILLED EXCEEDS MAXIMUM ALLOWED FOR THIS PRIOR AUTHORIZATION CHECK YOUR MAP-9 FORM
0533	CLAIM DENIED. PRIOR AUTHORIZATION NOT ON FILE OR DOES NOT MATCH CLAIM INFORMATION.
0534	CLAIM DENIED. PROCEDURE CODE X0064 CANNOT BE BILLED IN CONJUNCTION WITH OTHER PROCEDURE CODES.
0535	PLEASE BILL BABYS HOSPITAL STAY AFTER MOTHERS DISCHARGE ON SEPARATE CLAIM FORM, USING BABYS OWN NAME AND NUMBER
0536	THE MEDICARE EOMB INDICATES THIS IS A DUPLICATE BILLING. PLEASE SUBMIT THE ORIGINAL EOMB INDICATING THE DEDUCTIBLE AND CO-INSURANCE AMOUNTS.
0537	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAID SEPARATELY WHEN THE GLOBAL SERVICE HAS BEEN REPORTED.
0538	CLAIM/DETAIL DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION NUMBER.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0539	CLAIM/DETAIL DENIED. EPSDT RELATED SERVICES CLAIM EXCEEDS TOTAL UNITS OF SERVICE PRIOR AUTHORIZED.
0540	HOME HEALTH NURSING VISITS NOT REIMBURSED WHEN PRIVATE DUTY NURSING HAS BEEN AUTHORIZED THROUGH EPSDT SPECIAL SERVICES
0541	CAST APPLICATION OR REMOVAL HAS BEEN PAID SEPARATE OF SURGERY. RESUBMIT FOR ADJ WITH PAID RA OF CAST APPLICATION OR REMOVAL AND CORRECTED CLAIM
0542	DETAIL DENIED. IMPLANTABLES ARE LIMITED TO TWO UNITS OF SERVICE PER PROCEDURE, PER MEMBER, PER 90 DAYS.
0543	MULTIPLE SURGERIES FOR SAME DATE OF SERV MUST BE BILLED ON SAME CLAIM. YOUR CLAIM IS DENIED. INSTRUCTIONS FOR SUBMITTING AN ADJ ARE BEING FORWARDED.
0544	CLAIM/DETAIL DENIED. TELEHEALTH SERVICES ARE LIMITED TO 12 PER MEMBER PER 12 MONTHS.
0545	MULTIPLE MEDICAL/SURGICAL PROCEDURES FOR THE SAME DOS MUST BE BILLED ON THE SAME CLAIM. FILE AN ADJUSTMENT TO ADD ADDITIONAL PROCEDURES
0546	CLAIM/DETAIL DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN SIX (6) MONTHS OLD.
0547	CLAIM PAYMENT REDUCED. SPEND DOWN DEDUCTED.
0548	CLAIM/DETAIL DENIED. REVENUE CODE 235 MUST BE BILLED IN CONJUNCTION WITH REVENUE CODE 155, 183, AND/OR 185.
0550	PROCEDURE CODE 00140/D0140 CAN ONLY BE BILLED ALONE OR WITH MONITORED PROC CODES FOR THE SAME MEMBER, SAME PROVIDER, AND SAME DATE OF SERVICE.
0551	DISPENSING FEE DEDUCTED. IT WAS PAID WITH DISPENSING OF THE EMERGENCY SUPPLY.
0552	THE STAY DAYS BILLED EXCEEDS THE MAXIMUM NUMBER OF STAY DAYS FOR THIS INPATIENT HOSPITAL STAY.
0553	CLAIM DENIED. DRUG REQUIRES PRIOR AUTHORIZATION OR FIRST LINE THERAPY INITIATED.
0554	THE DATE OF SERVICE AND/OR DOLLAR AMOUNTS ON THE CLAIM AND MEDICARE EOMB DO NOT AGREE. PLEASE VERIFY AND RESUBMIT.
0555	DTL - CROSSOVER CLAIM EXCEEDS FILING LIMIT. LIMIT IS 12 MOS FROM MEDICARE EOMB DATE OR 36 MOS. FROM DATE OF SERVICE, WHICHEVER IS LATER.
0556	CLAIM/DETAIL DENIED. MEMBER MUST BE AN INPATIENT IN THE NURSING FACILITY.
0557	DTL - CROSSOVER CLAIM EXCEEDS FILING LIMIT. LIMIT IS 12 MONTHS FROM MEDICARE EOMB DATE OR 36 MOS FROM DATE OF SERVICE, WHICHEVER IS LATER.
0558	CLAIM DETAIL DENIED. H0039 LIMITED TO 32 UNITS PER DAY.
0559	CLAIM DENIED. THIS CLAIM EXCEEDS THE MONTHLY MAXIMUM UNITS FOR THIS NDC.
0560	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0561	INVALID NURSING HOME LEVEL OF CARE
0562	INVALID NURSING HOME LEVEL OF CARE
0563	INVALID LEVEL OF CARE PROV TYPE
0564	INVALID LOC FOR SNU PROVIDER
0565	THE SUM OF THE THIRD PARTY PAYMENT AMOUNTS ENTERED ON THE LINE ITEM(S) OF YOUR CLAIM IS NOT EQUAL TO THE AMOUNT ENTERED IN THE TPL TOTAL FIELD
0566	ELECTRONIC ADJUSTMENT/VOID SET TO DENY
0567	CLAIM DENIED. NO WAIVER LIABILITY BUCKET FOR MONTH OF SERVICE.
0568	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0569	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0570	DETAIL DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0571	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 30 DAYS OF THERAPY EXCEEDED DURING A 365 DAY PERIOD.
0572	DETAIL DENIED. LEAD INVESTIGATION IN THE HOME LIMITED TO TWO (2) SERVICES PER SIX MONTHS.
0573	DETAIL DENIED. POST HAZARD ABATE IN HOME LIMITED TO ONE (1) SERVICE PER 12 MONTHS.
0574	CLAIM DENIED. PRIOR AUTHORIZED AMOUNT HAS BEEN EXCEEDED.
0575	6TH SURGICAL PROCEDURE DATE INVALID
0576	ANCILLARY CHARGES NOT ALLOWED WITH PATIENT REVENUE CODES 180 OR 185
0578	CLAIM DENIED. PRIOR AUTHORIZATION REQUIRED IF 60 DAYS OF THERAPY EXCEEDED DURING A 3 YEAR PERIOD.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0579	CLAIM/DETAIL DENIED. REVENUE CODE 581 LIMITED TO 80 UNITS PER MEMBER PER CALENDAR WEEK (SUNDAY THROUGH SATURDAY).
0580	CLAIM/DETAIL DENIED. THE ANNUAL LIMITATION OF \$1000.00 PER MEMBER FOR MINOR HOME ADAPTATIONS HAS BEEN EXCEEDED.
0581	CLAIM/DETAIL DENIED. UNIVERSAL PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF EIGHT UNITS PER MEMBER, PER PREGNANCY.
0582	CLAIM/DETAIL DENIED. SELECTIVE PREVENTION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 76 UNITS PER MEMBER, PER PREGNANCY.
0583	MULTIPLE ANESTHESIA PROC CODES (00100-01999) FOR THE SAME RECIPIENT, PROVIDER AND DATES OF SERVICE ARE NOT ALLOWED
0584	CLAIM/DETAIL DENIED. CERTAIN OUTPATIENT SERVICES ARE LIMITED TO A COMBINED TOTAL OF 32 UNITS PER MEMBER, PER WEEK (SUNDAY THRU SATURDAY)
0585	CLAIM/DETAIL DENIED. INTENSIVE OUTPATIENT NON-RESIDENTIAL SERVICES PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 28 UNITS PER MEMBER, PER DAY.
0586	OCCURRENCE SPAN FROM DATE IS GREATER THAN THE OCCURRENCE SPAN TO DATE
0587	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 8 UNITS PER MEMBER, PER DAY.
0588	CLAIM/DETAIL DENIED. DAY REHABILITATION PROCEDURE CODES ARE LIMITED TO A COMBINED TOTAL OF 45 UNITS PER MEMBER, PER CALENDAR WEEK (SUNDAY THRU SATURDAY).
0590	4TH SURGERY DATE/STAY CONFLICT
0591	5TH SURGERY DATE/STAY CONFLICT
0592	6TH SURGERY DATE/STAY CONFLICT
0593	4TH SURGICAL PROCEDURE DATE INVALID
0594	5TH SURGICAL PROCEDURE DATE INVALID
0595	THE CLAIM WAS CREATED BY A RESUBMISSION
0596	CLAIM DETAIL DENIED. OFFICE VISITS NOT ALLOWED WITHIN 10 DAYS FOLLOWING A SURGICAL PROCEDURE.
0597	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE AFTER THE DATE OF DELIVERY.
0598	CLAIM DETAIL DENIED. ONLY ONE E AND M CODE ALLOWED PER DATE OF SERVICE.
0599	CLAIM PENDING REVIEW OF HISTORY
0600	EYE EXAM LIMITED TO OPTOMETRIST
0601	ONLY 3 FOLLOW UP EXAMS ARE ALLOWED PER 6 MONTHS
0602	CLAIM DENIED. LIMIT 2 ROUTINE ORTHODONTICS PER MEMBER, PER 12 MONTHS.
0603	CLAIM DENIED. EACH MEMBER ALLOWED ONE FULL MOUTH RADIOGRAPHY EVERY TWO YEARS PER PROVIDER.
0604	INVALID FINANCIAL CLASS CODE
0605	6TH THRU 11TH DIAG CODE IS NOT FOUND
0606	6TH DIAG CODE REQUIRES MED REVIEW
0607	7TH DIAG CODE REQUIRES MED REVIEW
0608	8TH DIAG CODE REQUIRES MED REVIEW
0609	9TH DIAG CODE REQUIRES MED REVIEW
0610	10TH DIAG CODE REQUIRES MED REVIEW
0611	11TH DIAG CODE REQUIRES MED REVIEW
0612	12TH - 24TH DIAG CODE REQUIRES MED REVIEW
0613	CLAIM HAS BEEN REVIEWED. REFER TO EOB 901-940 FOR DENIAL REASON.
0614	CLAIM HAS BEEN REVIEWED. REFER TO EOB 901-940 FOR DENIAL REASON.
0615	MAXIMUM OF 40 DAYS RESIDENTIAL RESPITE COMBINING DAILY AND HOURLY SERVICE PER MEMBER PER CALENDAR YEAR.
0616	MAXIMUM OF 60 DAYS IN-HOME RESPITE ALLOWED COMBINING DAILY AND HOURLY SERVICES PER MEMBER PER CALENDAR YEAR.
0617	MEMBER ALLOWED 1 INITIAL OFFICE VISIT WITH COMPLETE DIAGNOSIS PER 9 MONTHS
0618	4TH SURGICAL PROCEDURES/SEX CONFLICT
0619	5TH SURGICAL PROCEDURES/SEX CONFLICT
0620	6TH SURGICAL PROCEDURES/SEX CONFLICT
0621	4TH SURGICAL PROCEDURE NOT FOUND

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0622	5TH SURGICAL PROCEDURE NOT FOUND
0623	6TH SURGICAL PROCEDURE NOT FOUND
0624	CLAIM DENIED. THIS PROCEDURE ALLOWED ONE PER DOS PER TOOTH PER PROVIDER.
0625	CLAIM DENIED/MEMBER ALLOWED 3 REPAIRS INCLUDING REPLACEMENTS OF ONE TOOTH PER 12 MONTHS.
0626	CLAIM DENIED. ONLY 14 DAYS SERVICE ALLOWED PER ADMISSION PER MEMBER.
0627	CLAIM HAS BEEN REVIEWED. REFER TO EOB 901-940 FOR DENIAL.
0628	CLAIM HAS BEEN REVIEWED. REFER TO EOB CODES 1901 - 1940 FOR DENIAL REASON
0629	CLAIM HAS BEEN REVIEWED. REFER TO EOB 901-940 FOR DENIAL REASON.
0630	UNITS OF SERVICE NOT COMPATIBLE WITH DATE SPAN BILLED. IF ONLY ONE DOS BILLED, A DATE SPAN MAY BE REQUIRED FOR NUMBER OF UNITS BILLED.
0631	MEMBERS ARE LIMITED TO ONE DENTURE RELINING PER 12 MONTHS
0632	FULL MOUTH DEBRIDEMENT IS ALLOWED ONCE PER MEMBER PER PREGNANCY
0633	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION
0634	MAXIMUM \$300.00 ALLOWED PER MONTH/MEMBER FOR TANK OXYGEN
0635	AIS/MR DAILY CODE LIMITED TO ONE UNIT PER DATE OF SERVICE PER MEMBER
0636	PROFESSIONAL FEE FOR DISPENSING INITIAL PAIR OF EYEGLASSES ALLOW - ONE PER 12 MOS, PER MEMBER.
0637	CLAIM DENIED. MEMBER LIMITED TO 3 FETAL TESTS/12 MONTHS. IF UNUSUAL CIRCUMSTANCES, SEND CLAIM DOCUMENTATION TO AHCA FOR REVIEW.
0638	ANNUAL FAMILY PLANNING VISITS ARE LIMITED TO ONE PER MEMBER PER 9 MONTHS PER CLINIC
0639	CANNOT AUTO DENY ADJUSTMENT
0640	THIS DETAIL WAS MANUALLY PRICED AFTER REVIEW BY CONSULTANTS
0641	PRIOR AUTHORIZATION DOES NOT MATCH FOR THIS CLAIM/DETAIL
0642	THIS PROCEDURE IS LIMITED TO ONE PER 12 MONTHS PER MEMBER PER PROVIDER.
0643	CANNOT AUTO DENY ADJUSTMENT
0644	MEMBERS ARE LIMITED TO ONE (1) OPHTHALMOLOGICAL EXAMINATION PER PROVIDER PER 12 MONTHS
0645	NEW PATIENT HOME MEDICAL SERV LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS
0646	ESTABLISHED PATIENT MEDICAL SERVICES LIMITED TO ONE PER MEMBER PER PROVIDER PER 12 MONTHS
0647	PROVIDER NUMBER NOT ON FILE
0648	MEMBER ARE LMTD ON INITIAL PREVENTATIVE CARE VISITS TO 1 PER PROV PER 12 MONTHS.
0649	MEMBER LMTD 1 INITIAL OPHTHALMOLOGICAL SERVICE PER PROV PER 12 MONTHS
0650	ROUTINE NEWBORN CARE IS PAYABLE ONLY ONCE PER INFANT
0651	WAITING FOR PAPER ATTACHMENT FROM PROVIDER
0652	CLAIM DENIED. BIFOCAL OR SINGLE VISION LENSES ARE LIMITED TO 4 PER 12 MONTHS.
0653	CLAIM/DETAIL DENIED. A PRESCRIPTION CAN ONLY BE BILLED 6 TIMES.
0654	MEMBER ALLOWED FILLINGS FOR UP TO FIVE SURFACES PER TOOTH PER DOS PER PROVIDER
0655	MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER
0656	MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR
0657	MAXIMUM OF 45 HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER CALENDAR YEAR
0658	MAXIMUM OF 15 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER.
0659	MAXIMUM OF 30 CONSECUTIVE RESERVE DAYS ALLOWED PER MEMBER PER PROVIDER
0660	CALCULATED PAYMENT EQUALS ZERO. OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.
0661	SNU LEAVE DAYS PRESENT
0662	A MAXIMUM OF 14 INPATIENT HOSPITAL DAYS PER ADMISSION AND READMISSION PER MEMBER.
0664	PAY TO PROVIDERS MAIL IS UNDELIVERABLE. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTIONS.
0665	VENIPUNCTURE/CATHETERIZATION PROCEDURES 80020, 80022, 80023, 80024 AND 36415 NOT ALLOWED SAME DOS/MEMBER/PROVIDER
0666	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE.
0667	THIS PROCEDURE IS LIMITED TO ONE SERVICE PER MEMBER PER SAME DATE OF SERVICE
0668	PROVIDER/PROC CODE MOD/PLACE OF SERV CONFLICT. POST WITH ASC MOD 73 OR 74.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0669	DAYS REDUCED. A MAXIMUM OF 14 CONSECUTIVE HOSPITAL RESERVE DAYS ALLOWED PER MEMBER, PER PROVIDER.
0670	DAYS REDUCED. A MAXIMUM OF 15 NON-HOSPITAL RESERVE DAYS ALLOWED PER MEMBER, PER PROVIDER, PER CALENDAR YEAR.
0671	CLAIM/DETAIL DENIED. MEDICAID WILL PAY FOR ONLY ONE CARDIAC CATHETER PROCEDURE PER DAY.
0673	CLAIM DENIED. CPT LEVEL CODE MISSING OR INVALID.
0674	PROCEDURE CODE V5020 IS LIMITED TO 3 PER MEMBER PER PROVIDER PER SIX MONTHS
0675	CLAIM DETAIL DENIED. PROCEDURE CODE W0030 IS LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 60 DAYS.
0676	PROCEDURE W0030/V5011 CAN ONLY BE PERFORMED 150 TO 210 DAYS 5 TO 7 MONTHS AFTER PERFORMING PROCEDURE V5090
0677	PROCEDURE CODE LIMITED TO ONE PER 60 DAYS
0678	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 MONTHLY STABILIZATION VISITS DURING PHASE I TREATMENT CONTACT AHCA FOR FURTHER CONSIDERATION.
0679	CLAIM/DETAIL DENIED. ONLY ONE HANDS PROCEDURE CODE ALLOWED PER MEMBER PER DATE OF SERVICE.
0680	FAMILY AND/OR GROUP PSYCHOTHERAPY LMTD TO ONE PER DATE OF SERVICE
0681	PAY TO PROVIDER NONPARTICIPATING
0682	CLAIM DENIED. REIMBURSEMENT CANNOT EXCEED A MAXIMUM OF 14 DAYS PER ADMISSION.
0683	MODEL WAIVER MEMBERS ARE LIMITED TO 16 HOURS OF NURSING/ RESPIRATORY SERVICES PER DATE OF SERVICE
0684	MODEL WAIVER RESPIRATORY SERVICES ARE LIMITED TO ONE UNIT PER MEMBER PER DATE OF SERVICE
0685	CLAIM/DETAIL DENIED. A HOSPICE SERVICE HAS BEEN PAID FOR SAME MEMBER/SAME DATE(S) OF SERVICE.
0686	CLAIM/DETAIL DENIED. HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE CONSECUTIVE DAYS PER MEMBER.
0687	UNITS BILLED EXCEED MAXIMUM FOR THIS PRIOR AUTHORIZATION
0688	MODEL WAIVER DOLLAR LIMIT HAS BEEN MET
0689	MEMBERS ARE LIMITED TO A MAXIMUM OF 365 ORAL CONTRACEPTIVE UNITS PER 12 MONTH PERIOD
0690	CLAIM DENIED. TARGETED CASE MANAGEMENT SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH, PER MEMBER.
0691	CLAIM/DETAIL DENIED. CLIA ID MISSING OR INVALID
0692	CLAIM/DETAIL DENIED. PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE.
0693	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO ONE PER MEMBER PER 12 MONTHS
0694	COMPREHENSIVE ORTHODONTIC EXAM LIMITED TO TWO (2) PER MEMBER PER LIFETIME
0695	MEMBERS ARE LIMITED TO A MAXIMUM OF 24 MONTHLY RETENTION VISITS PER LIFETIME
0696	CLAIM/DETAIL DENIED. PROFESSIONAL COMPONENT CHARGES MUST BE BILLED ON HCFA-150
0697	MEMBERS ARE LIMITED TO ONE RETENTION VISIT PER 30 DAYS
0698	MEMBERS ARE LIMITED TO A MAXIMUM OF 10 POST TREATMENT STABILIZATION VISITS PER LIFETIME
0699	CLAIM/DETAIL DENIED. PROCEDURE CODE T2022 IS LIMITED TO \$260.00 IN
0700	CLINIC PROVIDER IS INELIGIBLE FOR THIS CATEGORY OF SERVICE.
0701	CLAIM DENIED. BED RESERVE REVENUE CODES FOR MENTAL HOSPITAL AND ACUTE PSYCHIATRIC BED ARE LIMITED TO A COMBINATION OF 14 UNITS PER CALENDAR YEAR PER MEMBER
0702	CLAIM DENIED. BED RESERVE/OTHER REVENUE CODE IS LIMITED TO A TOTAL OF 21 UNITS PER CALENDAR 6 MONTHS PER MEMBER, PER PROVIDER.
0703	CLAIM DENIED. BED RESERVE/ACUTE REVENUE CODE IS LIMITED TO A TOTAL OF 14 UNITS PER CALENDAR 6 MONTHS PER MEMBER, PER PROVIDER.
0704	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CLAIMS ARE LIMITED TO 30 CONSECUTIVE BED RESERVE DAYS PER MEMBER, PER PROVIDER.
0705	NEW PATIENT OPHTHALMOLOGICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0706	NEW PATIENT OFFICE OR OUTPATIENT SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS
0707	NEW PATIENT HOME MEDICAL SERVICES LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS
0708	NEW PATIENT PREVENTATIVE CARE VISITS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER 36 MONTHS/THREE YEARS
0709	CLAIM/DETAIL DENIED. PROCEDURE CODE 70320 LIMITED TO ONE PER YEAR, PER MEMBER, PER PROVIDER.
0710	CLAIM/DETAIL DENIED. ONLY ONE CHEMOTHERAPY ADMINISTRATION CODE IS PAYABLE PER DATE OF SERVICE.
0711	PROVIDER NOT APPROVED FOR ELECTRONIC BILLING SUBMIT MAP 380 PROVIDER AGREEMENT FORM
0712	PROCEDURE CODE/PROVIDER TYPE OF SERVICE CONFLICT (WAIVER PROGRAM AND CASE MANAGEMENT)
0713	DELIVERY, ROUTINE NEWBORN CARE, CIRCUMCISION ARE LIMITED TO ONE EACH PER EACH PER MEMBER PER DATE OF SERVICE
0715	CLAIM DENIED. PROCEDURE CODE X0064 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
0716	CLAIM DENIED. PROCEDURE CODE X0074 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
0717	CLAIM DENIED. PROCEDURE CODE X0075 LIMITED TO A TOTAL OF 76 UNITS OF SERVICE PER PROVIDER, PER MEMBER, PER TWO YEARS.
0718	CLAIM DENIED. PROCEDURE CODE X0076/T2022 LIMITED TO ONE UNIT OF SERVICE PER PROVIDER, PER MEMBER, PER CALENDAR MONTH.
0719	CLAIM DENIED. A MAXIMUM OF 60 RESPITE DAYS (COMBINING DAILY AND HOURLY SERVICES) ALLOWED PER PROVIDER, PER MEMBER, PER CALENDAR YEAR.
0720	MEDICARE COVERAGE IS PRESENT
0721	RECIP INELIG FOR DATE OF SRV - DENIED AFTER BEING PENDED FOR 14 DAYS AWAITING DCF UPDATE. IF YOU HAVE ELIG PROOF CONTACT DCF DISTRICT OFFICE.
0722	CLAIM/DETAIL DENIED. BUCCAL AND FACIAL TOOTH SURFACES NOR OCCLUSAL AND INCISAL TOOTH SURFACES NOT ALLOWED FOR SAME MEMBER, SAME PROV, SAME DOS.
0723	CLAIM/DETAIL DENIED. ONLY FOUR TOOTH SURFACES ALLOWED PER MEMBER, PER PROVIDER, PER DATE OF SERVICE, PER TOOTH NUMBER.
0724	CLAIM DETAIL DENIED. HOME MODIFICATIONS ARE LIMITED TO \$1000.00 IN PAYMENTS PER SIX MONTHS.
0725	INDIVIDUAL PSYCHOTHERAPY IS LIMITED TO 12 UNITS OF SERVICE PER DAY, PER MEMBER, PER PROVIDER
0726	CLAIM/DETAIL DENIED. CEPHALOMETRIC X-RAY LIMITED TO ONE PER MEMBER, PER PROVIDER, EVERY TWO YEARS.
0727	CLAIM/DETAIL DENIED. DIALYSIS TRAINING LIMITED TO ONE (1) PER MEMBER, PER LIFE TIME.
0728	GINGIVECTOMY PROCEDURE IS LIMITED TO ONE PER MEMBER, PER PROVIDER, PER TOOTH NUMBER PER 12 MONTHS
0729	PIN RETENTION THERAPY TREATMENT IS LIMITED TO TWO PER MEMBER PER PERMANENT MOLAR PER LIFETIME
0730	PROCEDURE CODE 07880/D7880 LIMITED TO ONE PER LIFETIME PER MEMBER
0731	MEMBERS ARE LIMITED TO ONE RELINING OF THE LOWER DENTURE PER 12 MONTHS
0732	ALVEOPLASTY PROCEDURE CODES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURS WITH ONLY ONE PER QUADRANT, PER MEMBER, PER LIFETIME
0733	PROCEDURES ARE LIMITED TO ANY COMBINATION OF THESE PROCEDURES WITH ONLY ONE EACH PER QUADRANT, PER MEMBER, PER 12 MONTH PERIOD, PER PROVIDER
0734	CLAIM/DETAIL DENIED. PROCEDURE IS NOT ALLOWED TO THE SAME TOOTH ON THE SAME DATE OF SERVICE AS A SEALANT.
0735	CLAIM/DETAIL DENIED. SYRINGES LIMITED TO 125 UNITS PER 26 DAYS, PER MEMBER.
0736	CLAIM/DETAIL DENIED. VACCINE ADMINISTRATION LIMITED TO (3) PER MEMBER, PER PROVIDER, PER DATE OF SERVICE.
0737	INVALID PROCEDURE CODE AND MODIFIER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0738	CLAIM/DETAIL DENIED. SEALANTS ARE LIMITED TO THREE PER TOOTH PER LIFETIME PER MEMBER.
0739	CLAIM/DETAIL DENIED. SEALANTS ARE NOT ALLOWED TO A TOOTH THAT HAS RECEIVED AN OCCLUSAL FILLING.
0740	CLAIM/DETAIL DENIED. ONLY ONE UNIT OF SERVICE ALLOWED FOR THIS DENTAL PROCEDURE PER PRIOR AUTHORIZATION.
0742	DETAIL DENIED. INTRAORAL COMPLETE SERIES LIMITED TO ONE UNIT PER MEMBER, PER PROVIDER, PER 12 MONTHS.
0743	GINGIVECTOMY LIMITED TO 1 UNIT PER TOOTH, PER 12 MONTHS, PER MEMBER, PER PROVIDER
0744	CLAIM/DETAIL DENIED. SCHOOL-BASED HEALTH SERVICES ARE LIMITED TO 40 UNITS OF SERVICE PER DATE OF SERVICE. PLEASE CHECK THE UNITS OF SERVICE BILLED FOR ERRORS
0745	CLAIM/DETAIL DENIED. PROCEDURE CODE X0058 CANNOT BE BILLED BY A SCHOOL BASED PROVIDER AND A COMMUNITY MENTAL HEALTH PROVIDER ON THE SAME DATE OF SERVICE.
0746	REVENUE/PROCEDURE CODE INVALID FOR PROVIDER TYPE
0747	CLAIM DETAIL DENIED. PROCEDURE CODES X0079/H0039 AND X0098/97537, (ANY COMBINATION) ARE LIMITED TO FORTY HOURS PER SEVEN DAY PERIOD.
0748	REVENUE/PROCEDURE CODE INVALID FOR PLACE OF SERVICE
0749	CLAIM DETAIL DENIED. RESPITE CARE IS LIMITED TO 168 HOURS PER SIX MONTHS.
0750	DRUG/DRUG INTERACTION
0751	REVENUE/PROCEDURE CODE INVALID FOR DATE OF SERVICE
0752	REVENUE CODE MISSING/INVALID
0753	INVALID REVENUE CODE. CHARGES NOT ALLOWED.
0754	EARLY REFILL
0755	NON-REIMBURSABLE FOR THIS PROVIDER TYPE/DOS. EFFECTIVE FOR DOS 10/01/90 AND AFTER, DRUGS MUST BE BILLED BY MEDICAID PARTICIPATING PHARMACY.
0756	CLIA ID MISSING OR INVALID. CHARGES MOVED TO NON-COVERED.
0757	CHARGES MOVED TO NON-COVERED. RTSUP CAN ONLY BE REIMBURSED WHEN CHARGES FOR RT ARE BILLED FOR THE SAME DATES OF SERVICE.
0758	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED LAB CODE. CHARGES MOVED TO NON-COVERED.
0759	PROVIDER NOT CLIA CERTIFIED TO BILL NON-WAIVERED OR NON-MICROSCOPY LAB CODE. CHARGES MOVED TO NON-COVERED.
0760	INFERRED DRUG/DISEASE PRECAUTION
0761	DRUG/AGE PRECAUTION
0762	MEDICAL CONDITION ALERT
0763	SERVICES RENDERED DO NOT MEET DMS CRITERIA
0764	DIAGNOSIS AND DESCRIPTION OF TREATMENT ARE REQUIRED FOR SERVICES RENDERED
0765	THERAPEUTIC DUPLICATION
0766	REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED
0767	INGREDIENT DUPLICATION
0768	ALCOHOL PRECAUTION
0769	BREAST FEEDING PRECAUTION
0770	DRUG/FOOD INTERACTION
0771	DRUG/LAB CONFLICT
0772	CALL HELP DESK (1-800-807-1232)
0773	INVALID DUR CONFLICT CODE
0774	INVALID DUR INTERVENTION CODE
0775	INVALID DUR OUTCOME CODE
0777	CLAIM DENIED. PHARMACY CLAIMS MUST BE BILLED THROUGH POS
0778	VARIANCE LIMIT MET. CLAIM PENDING REVIEW.
0779	INVALID PROCEDURE CODE MODIFIER
0781	CLAIM/DETAIL DENIED. THE MEMBERS ANNUAL SPEECH THERAPY VISIT LIMIT.
0782	CLAIM/DETAIL DENIED. THE MEMBERS ANNUAL PHYSICAL THERAPY VISIT LIMIT.
0783	FULL MOUTH DEBRIDEMENT NOT ALLOWED ON SAME DATE OF SERVICE AS PROPHY OR
0784	PROPHY OR PERIODONTAL SCALING AND ROOT PLANNING NOT ALLOWED ON SAME DATE
0785	CLAIM/DETAIL DENIED. ONLY ONE DENTAL VISIT ALLOWED PER MEMBER PER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0786	CLAIM/DETAIL DENIED. CAST PROCEDURES ARE LIMITED TO TWO PER 90 DAYS PER
0788	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO FIVE (5) DAYS PER
0789	CLAIM/DETAIL DENIED. ADULT DAY TRAINING ON-SITE IS LIMITED TO EIGHT (8).
0790	CLAIM/DETAIL DENIED. ADULT DAY TRAINING IS LIMITED TO 255 DAYS PER
0791	CLAIM/DETAIL DENIED. REVENUE CODE 580 IS LIMITED TO 45 UNITS (HOURS) PER WEEK (SUNDAY THROUGH SATURDAY).
0792	CLAIM/DETAIL DENIED. ONLY ONE OBSTETRICAL VISIT ALLOWED IN AN EIGHT WEEK PERIOD.
0793	CLAIM/DETAIL DENIED. ONLY ONE COMPREHENSIVE VISIT ALLOWED EVERY 50 WEEKS.
0794	CLAIM/DETAIL DENIED. EPIDURAL INJECTIONS FOR CONTROL OF PAIN SHALL BE LIMITED TO 3 INJECTIONS PER 6 MONTHS PER MEMBER.
0795	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE MONTHLY (CALENDAR MONTH) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.
0796	CLAIM/DETAIL REQUIRES PRIOR AUTHORIZATION. THE ANNUAL (CALENDAR YEAR) LIMITATION FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.
0797	THE ANNUAL MAXIMUM FOR THIS SERVICE HAS BEEN EXCEEDED. THE ALLOWED
0798	PROCEDURE CODE XZ299 IS LIMITED TO \$150.00 PER CALENDAR MONTH PER MEMBER, PER PROVIDER
0799	REVENUE CODE 270 CANNOT EXCEED \$2,000 BILLED AMOUNT PER MONTH. PLEASE RESUBMIT WITH ITEMIZED INVOICE FOR SUPPLIES FOR ENTIRE MONTH.
0800	CLAIM DENIED. PROCEDURE CODES X0074 AND X0075 NOT PAYABLE ON SAME DATE OF SERVICE AS X0076.
0801	CLAIM DENIED. PROCEDURE CODE X0076 NOT PAYABLE ON THE SAME DATE OF SERVICE AS X0074 OR X0075.
0802	PROCEDURE CODE 00150/D0150 DISALLOWED BY SAME PROVIDER FOR SAME MEMBER ON THE SAME DATE OF SERVICE AS PROCEDURES 09110/D9110 OR 00140/D0140
0803	MEMBER APPLIED INCOME NOT CURRENT FOR DOS - RECYCLE FOR EDIT 271
0808	MONTHLY DIALYSIS PROCEDURE CODES ARE NOT REIMBURSEABLE FOR THE SAME OR OVERLAPPING DATE OF SERVICE AS DAILY DIALYSIS PROCEDURE CODES
0810	HEMODIALYSIS PROCEDURE CODES ARE NOT REIMBURSABLE FOR THE SAME OR OVERLAPPING DATES OF SERVICE AS EVALUATION AND MANAGEMENT PROCEDURE CODES.
0812	ADDITIONAL SURGICAL PROCEDURES ARE NOT PAYABLE ON SAME DATE OF SERVICE BY SAME PROVIDER FOR SAME MEMBER WHEN BILLING FOR SUTURE OF WOUND
0814	MEMBER ID NUMBER IS INVALID
0815	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE NOT PAYABLE ON THE SAME DATE OF SERVICE AS COMMUNITY RESIDENTIAL SERVICES.
0816	CAST REMOVAL OR REPAIR HAS BEEN PAID WITH APPLICATION OF CAST. IF UNRELATED PROC, SEND CLAIM WITH DOCUMENTATION OF UNRELATED PROC TO THE AHCA FOR REVIEW.
0818	VENIPUNCTURE OR ARTERIAL PUNCTURE IS NOT ALLOWED ON THE SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES
0821	CLAIM/DETAIL DENIED. LIMITATION EXCEEDED, PRIOR AUTHORIZATION REQUIRED.
0822	X-RAY PROCEDURE NOT ALLOWED WITHIN 12 MONTHS OF INTRAORAL COMPLETE SERIES
0824	DETAIL DENIED. PROCEDURE CODE 08670 NOT PAYABLE WITHIN 24 MONTHS OF CERTAIN OTHER PROCEDURE CODES IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER.
0825	DETAIL DENIED. THIS PROC CODE NOT PAYABLE WITHIN 24 MONTHS OF ORTHODONTIC TREATMENT IF BILLED FOR THE SAME MEMBER BY THE SAME PROVIDER.
0826	PROCEDURE CODE 09110/D9110 NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR OTHER DENTAL PROCEDURE CODES FOR THE SAME DATE OF SERVICE
0827	THIS PROCEDURE IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR PROCEDURE 09110/D0110 FOR THE SAME DATE OF SERVICE
0828	CLAIM/DETAIL DENIED. THIS REVENUE CODE IS NOT PAYABLE FOR THIS PROVIDER SPECIALTY CODE.
0829	CLAIM/DETAIL DENIED. PROVIDER NOT ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES PROVIDED TO KCHIP PHASE III MEMBERS.
0830	CLAIM DENIED. NO DRG FOUND.
0831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0832	CLAIM DENIED. DRG CRITERIA NOT MET.
0833	CLAIM DENIED. DRG INVALID AGE.
0834	CLAIM DENIED. DRG INVALID SEX.
0835	CLAIM DENIED. DRG INVALID DISCHARGE STATUS.
0836	CLAIM DENIED. DRG INVALID PRINCIPLE DIAGNOSIS.
0837	CLAIM DENIED. DRG DENY 469 THROUGH 470.
0838	PROCEDURE CODE T2033 LIMITED TO ONE UNIT PER DAY PER MEMBER
0839	RESERVED FOR DRG
0840	PROCEDURE CODE HAS BEEN REBUNDLED
0841	BYPASS INDICATOR, GMIS INFORMATIONAL ONLY
0842	PROCEDURE CODE IS MUTUALLY EXCLUSIVE
0843	PROCEDURE CODE IS INCIDENTAL
0844	PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT
0845	VISIT IS WITHIN ONE DAY PRE OP RANGE
0846	PROCEDURE CODE INCLUDES UNILATERAL AND BILATERAL PERFORMANCE
0847	PROCEDURE IS A BILATERAL OR DUPLICATE
0848	PLEASE PAY SPECIFIED PROCEDURE CODES
0849	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON
0850	PROCEDURE CODE IS INVALID FOR PATIENTS AGE
0851	PROCEDURE CODE IS INVALID FOR PATIENTS SEX
0852	GMIS - INAPPROPRIATE PROCEDURE CODE FOR MEMBERS AGE
0853	PEDIATRIC PROCEDURE AGE SHOULD BE 1 TO 17 YEARS
0854	MATERNITY PROCEDURE AGE SHOULD BE 12 - 55 YEARS
0856	PROCEDURE NOT INDICATED FOR A MALE
0857	PROCEDURE NOT INDICATED FOR A FEMALE
0858	CLAIM DENIED. COSMETIC PROCEDURE.
0859	CLAIM DENIED. DUPLICATE PROCEDURE.
0860	CLAIM DENIED. EXPERIMENTAL PROCEDURE.
0861	CLAIM DENIED. OBSOLETE PROCEDURE.
0863	PROCEDURE CODES DOES NOT REQUIRE AN ASSISTANT SURGEON
0864	PROCEDURE CODE IS INVALID FOR LOCATION
0865	PROCEDURE CODE NEEDS TO BE REPLACED
0866	PROCEDURE NEEDS TO BE REPLACED FOR SURFACES BILLED
0867	PROCEDURE CODE NEEDS TO BE REPLACED FOR SURFACES BILLED
0868	CLAIM/DETAIL DENIED. PURCHASE OF PROCEDURE CODES E0607 AND E2100 IS
0872	FIRST DIAGNOSIS CODE NOT ON FILE
0873	SECOND DIAGNOSIS CODE NOT ON FILE
0874	SECOND DIAGNOSIS CODE INVALID
0875	THIRD DIAGNOSIS CODE NOT ON FILE
0876	CLAIM/DETAIL DENIED. HEARING AIDS ARE LIMITED TO \$1400.00 PER EAR, PER
0877	CLAIM/DETAIL DENIED. CHILDRENS DENTAL PROPHYLAXIS AND FLOURIDE
0878	FOURTH DIAGNOSIS CODE NOT ON FILE
0879	CLAIM DENIED. PROCEDURE REQUIRES DOCUMENTATION
0880	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS UP TO AGE 14
0881	CLAIM DENIED. PROCEDURE CODE IS FOR PATIENTS OVER AGE 14.
0882	CLAIM DENIED. COSMETIC PROCEDURE NOT PAYABLE BY MEDICAID
0883	CLAIM DENIED. DUPLICATE PROCEDURE HAS BEEN PAID.
0884	CLAIM DENIED PROCEDURE IS CONSIDERED EXPERIMENTAL
0885	FIFTH DIAGNOSIS CODE NOT ON FILE
0886	FIFTH DIAGNOSIS CODE NOT ON FILE
0887	6TH THRU 11TH DIAG CODE IS NOT FOUND
0888	6TH THRU 11TH DIAG CODE IS NOT FOUND
0889	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE IS NOT PAYABLE IF BILLED WITH A SUBSTANCE ABUSE DIAGNOSIS CODE.

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EOB Code	EOB Description
0890	CLAIM/DETAIL DENIED. THIS PROCEDURE IS NOT PAYABLE IF BILLED WITHOUT ONE OF THE DESIGNATED PREGNANCY DIAGNOSIS CODES.
0891	6TH THRU 11TH DIAG CODE IS NOT FOUND
0892	6TH THRU 11TH DIAG CODE IS NOT FOUND
0893	UNITS OF SERVICE GREATER THAN THE REMAINING PRIOR AUTHORIZED AMOUNT
0894	DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET.
0896	CLAIM HAS FAILED MORE THAN 24 ERROR CODES. PLEASE CORRECT AND RESUBMIT.
0897	6TH THRU 11TH DIAG CODE IS NOT FOUND
0898	6TH THRU 11TH DIAG CODE IS NOT FOUND
0899	6TH THRU 11TH DIAG CODE NOT FOUND
0900	THE RX NUMBER MUST BE COMPLETED TO PROCESS YOUR CLAIM. PLEASE COMPLETE AND RESUBMIT YOUR CLAIM.
0901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT YOUR CLAIM.
0902	CLAIM DENIED. DRUG QUANTITY BILLED FOR ESTABLISHED MINIMUM/MAXIMUM QUANTITIES.
0903	CLAIM DENIED. DRUG DAYS SUPPLY MISSING OR INVALID.
0904	CLAIM DENIED. NDC IS RATED DESI FOR CLAIM DATE OF SERVICE.
0905	ACKNOWLEDGMENT FORM MISSING
0906	ACKNOWLEDGEMENT FORM INVALID/INCOMPLETE
0907	CLAIM DENIED. NDC IS TERMINATED OR OBSOLETE.
0908	CLAIM/DETAIL IS DENIED. THE MEMBER IS IN A NURSING FACILITY ON THE DATE OF SERVICE
0909	CLAIM DETAIL DENIED. ANCILLARY SERVICES NOT AUTHORIZED BY THE PRO.
0910	CLAIM DENIED. SUBMITTED LEVEL OF CARE SERVICES NOT AUTHORIZED BY THE PRO.
0911	MODIFIER INVALID FOR PROCEDURE CODE BILLED
0912	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN 2 DAYS ARE NOT ALLOWED.
0913	CLAIM DENIED. OUTPATIENT HOSPITAL CLAIMS FOR MORE THAN TWO DAYS ARE NOT ALLOWED.
0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
0915	CLAIM/DETAIL DENIED. THE NON-COVERED AMOUNT CANNOT BE GREATER THAN THE BILLED AMOUNT.
0916	EPSDT SPECIAL SERVICES/SCHOOL BASED HEALTH SERVICES CLAIMS NOT PAYABLE FOR THIS MEMBER
0917	CLAIM/DETAIL DENIED. SCREENING PROCEDURE CODE INVALID FOR MEMBERS AGE.
0918	CLAIM/DETAIL DENIED. THE DETAIL DATES OF SERVICE ARE NOT EQUAL TO OR WITHIN THE HEADER DATES OF SERVICE.
0919	CONSENT FORM INVALID. YOU MAY CORRECT ANY ITEM ON THE FORM EXCEPT SIGNATURE AND DATE OF PATIENT/PERSON OBTAINING CONSENT AND INTERPRETER.
0920	CLAIM DENIED. A PRESCRIPTION CAN ONLY BE BILLED 12 TIMES.
0921	CLAIM DENIED. THIRD PARTY LIABILITY AMOUNT IS EQUAL TO MEDICARE PAID AMOUNT OR GREATER THAN HEADER COINSURANCE PLUS HEADER DEDUCTIBLE.
0922	THIS SERVICE WAS NOT PAID BY MEDICARE. MEDICAID PAYMENT CAN ONLY BE MADE FROM A PAID MEDICARE EOMB.
0923	CLAIM DENIED. A NINE-BYTE, ALL-NUMERIC TAX ID-NUMBER MUST BE ENTERED IN THE PATIENTS ACCOUNT NUMBER FIELD ON THE CLAIM.
0924	CLAIM DENIED. DISPROPORTIONATE SHARE HOSPITAL CLAIMS WHICH SPAN A MEMBERS 6TH BIRTHDAY MUST BE SPLIT BILLED.
0925	CLAIM/DETAIL DENIED. VENIPUNCTURE AND ARTERIAL PUNCTURE NOT ALLOWED ON SAME DATE OF SERVICE AS OTHER MONITORED PROCEDURES.
0926	CLAIM/DETAIL DENIED. THIS SERVICE NOT PAYABLE ON THE SAME DATE OF SERVICE AS VENIPUNCTURE AND ARTERIAL PUNCTURE.
0927	CLAIM DENIED. THE CLINIC NUMBER MUST BE ENTERED.
0928	DETAIL DENIED. A VALID 5-DIGIT MODIFIER MUST BE ENTERED.
0929	CLAIM/DETAIL DENIED. ANESTHESIA LIMITED TO ONE PER MEMBER PER PROVIDER PER DATE OF SERVICE.
0930	CLAIM/DETAIL DENIED. MEMBER HAS THIRD PARTY LIABILITY (MEDICARE REPLACEMENT POLICY) COVERAGE ON FILE.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0931	CLAIM DENIED. COMPOUND CODE MISSING OR INVALID.
0932	CLAIM/DETAIL DENIED. ONE DIALYSIS SERVICE ALLOWED PER RECIPIENT, PER PR
0933	CLAIM DENIED. UNIT DOSE INDICATOR MISSING OR INVALID.
0935	DRUG INCOMPATABILITY ALERT
0936	CLAIM DENIED. MEMBER IN ANOTHER INSTITUTIONAL SETTING DURING THE SAME DATE(S) OF SERVICE.
0937	CLAIM DENIED. PRESCRIPTION NUMBER REFILL DATE IS GREATER THAN ONE YEAR OLD.
0938	CLAIM/DETAIL DENIED. MAXIMUM OF TEN NON-HOSPITAL RESERVE DAYS ALLOWED
0939	CLAIM/DETAIL DENIED. MAXIMUM OF 14 HOSPITAL RESERVE DAYS ALLOWED PER
0941	CLAIM DENIED. CURRENT PROVIDER LICENSE NOT ON FILE.
0942	CLAIM DENIED. REVENUE CODE 129 IS NOT VALID WITH ANY OTHER ACCOMMODATION REVENUE CODE.
0943	CLAIM/DETAIL DENIED. FRAMES OR COMPONENTS OF FRAMES ARE LIMITED TO 2
0944	LOW DOSE ALERT
0945	HIGH DOSE ALERT
0946	LATE REFILL
0947	MINIMUM DURATION ALERT
0948	MAXIMUM DURATION ALERT
0949	DRUG ALLERGY ALERT
0950	CLAIM DENIED. THIS SERVICE IS NOT PAYABLE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY MEMBERS.
0951	THIS SERVICE IS NOT COVERED BY MEDICAID
0952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT
0953	CONSENT FORM INCOMPLETE. YOU MAY COMPLETE ANY ITEM ON FORM EXCEPT, SIGNATURE AND DATE OF PATIENT PERSON OBTAINING CONSENT AND INTERPRETER.
0954	CLAIM DETAIL DENIED. THE PROCEDURE CODE MODIFIER IS MISSING OR INVALID.
0955	CLAIM/DETAIL DENIED. PROVIDER SPECIALITY INVALID FOR MODIFIER GT.
0956	THIS PROFESSIONAL CANNOT BILL THIS PROCEDURE CODE
0957	CMHC PROCEDURES X0054 OR X0152 PAYABLE ONLY WHEN BILLED WITH ANOTHER CMHC PROCEDURE CODE
0958	EFFECTIVE WITH DATES OF SERVICE ON OR AFTER 07-01-93, A FIVE DIGIT MODIFIER MUST BE BILLED ON COMMUNITY MENTAL HEALTH CENTER CLAIMS.
0959	PRIOR ADVERSE DRUG REACTION
0960	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE ACCOMMODATION REVENUE CODE 100. CHARGES MOVED TO NON-COVERED.
0961	THIS REVENUE CODE IS NOT PAYABLE WHEN BILLED WITH ALL INCLUSIVE REVENUE CODE 101 AND ALL INCLUSIVE ANCILLARY REVENUE CODE 240. CHARGES MOVED TO NON-COVERED.
0962	PREGNANCY ALERT.
0963	DRUG/GENDER ALERT
0964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 21.
0965	CLAIM DENIED. CHILDRENS TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 20.
0966	CLAIM DENIED. ADULT TARGETED CASE MANAGEMENT SERVICES ARE NOT PAYABLE TO MEMBERS UNDER AGE 18.
0967	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO TWO UNITS OF SERVICE PER DAY.
0968	CLAIM DENIED. REIMBURSEMENT FOR THIS REVENUE CODE IS LIMITED TO ONE UNIT OF SERVICE PER DAY.
0969	THIS PROCEDURE CODE REQUIRES THE ENTRY OF A VALID QUADRANT CODE IN THE TOOTH NUMBER FIELD
0970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIELD
0971	LITER FLOW PER MINUTE AND/OR NUMBER OF HOURS MISSING OR INVALID
0972	CLAIM DENIED. PROCEDURE CODES FOR MILEAGE, OXYGEN AND SUPPLIES MUST MATCH THE BASE RATE CATEGORY.

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
0973	PIN RETENTION THERAPY IS LIMITED TO ONE TOOTH PER DETAIL
0974	DUPLICATE TOOTH NUMBERS ARE NOT ALLOWED ON THE SAME DETAIL FOR GINGIVECTOMY PROCEDURE
0975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCEDURE GINGIVECTOMY PROCEDURE
0976	PIN RETENTION THERAPY IS LIMITED TO PERMANENT MOLARS ONLY
0977	TYPE OF BILL INVALID FOR PROVIDER TYPE
0978	CLAIM DENIED. ONLY ONE BASE RATE PROCEDURE CODE ALLOWED PER CLAIM.
0979	CLAIM DENIED. EMERGENCY TRANSPORTATION CLAIMS WITH DATES OF SERVICE ON OR AFTER 7/1/95 MUST BE SUBMITTED ON PAPER.
0980	COPAY FOR THIS SERVICE IS ADDITIVE. THE COPAY AMOUNT WAS CREDITED TO
0981	CLAIM DENIED. PAPER BILLING ONLY ALLOWED FOR MEMBERS IN CERTAIN COUNTIES, FOR CERTAIN PROCEDURE CODES, FOR DOS AFTER 11/30/02.
0982	CLAIM/DETAIL DENIED. VACCINE PROCEDURE CODE MUST BE BILLED USING MODIFIER 26 FOR ADMINISTRATION TO INDICATE VACCINE OBTAINED FROM PRIVATE SOURCE.
0984	MEDICARE EOMB DOES NOT INDICATE THAT COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE.
0985	DETAIL DENIED. THIS PROCEDURE LIMITED TO TWO UNITS OF SERVICE.
0986	DETAIL DENIED. PROCEDURE CODE A0420 MUST ALSO BE BILLED WHEN AN EXTRA MILEAGE PROCEDURE CODE IS BILLED WITH A ROUND TRIP PROCEDURE CODE.
0987	DETAIL DENIED. PROCEDURE CODES A0070 AND A0422 LIMITED TO 1 UNIT OF SERVICE IF BASE RATE INDICATES ONE WAY TRIP.
0988	HEADER MEDICARE ALLOWED AMOUNT IS NOT EQUAL TO THE SUM OF THE DETAIL MEDICARE ALLOWED AMOUNTS
0989	CLAIM/DETAIL DENIED. RETURN MILEAGE NOT PAYABLE WHEN BILLING FOR ONE WAY TRIP.
0990	DETAIL DENIED. SERVICES NOT PAYABLE BEYOND THE MONTH OF THE MEMBERS THIRD BIRTHDAY.
0992	DETAIL DENIED. PROCEDURE CODE INVALID FOR PROVIDER TYPE 13.
0993	CLAIM/DETAIL DENIED. SERVICES NOT PAYABLE ON SAME DATE OF SERVICE AS AIR AMBULANCE.
0994	CLAIM/DETAIL DENIED. MILEAGE PROCEDURE CODES NOT PAYABLE SAME DATE OF SERVICE AS ADDITIONAL PASSENGER PROCEDURE CODES.
0996	NUMBER OF STUDENTS IN GROUP MISSING OR INVALID
0997	CLAIM PAID ZERO DUE TO INVALID PRESCRIBER LICENSE NUMBER. PLEASE RESUBMIT AN ADJUSTMENT WITH CORRECTED VALID PRESCRIBER LICENSE NUMBER.
0998	CLAIM TEMPORARILY SUSPENDED UNTIL NEW FEE UPDATE IS IMPLEMENTED
0999	PENDING FOR REVIEW
1000	INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
1001	THERAPY NOT COVERED FOR RECIPIENTS UNDER 21 YEARS OF AGE
1002	PRESCRIBER NOT ACTIVE
1003	APD GATEKEEPER ADJUSTMENT
1006	FACILITY PROV NOT ELIG AT SERV LOC FOR PROG BILLED
1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP
1011	SYSTEM ERROR
1018	NO PRICING SEGMENT FOR LEVEL OF CARE
1020	SURGERY DATE AFTER BILLING DATE
1021	SURGERY DATE AFTER BILLING DATE
1022	SURGERY DATE AFTER BILLING DATE
1023	SURGERY DATE AFTER BILLING DATE
1024	SURGERY DATE AFTER BILLING DATE
1025	SURGERY DATE AFTER BILLING DATE
1026	SURGERY DATE AFTER BILLING DATE
1027	FIRST SURGICAL PROCEDURE CODE NOT ON FILE
1028	SECOND SURGICAL PROCEDURE NOT ON FILE
1029	THIRD SURGICAL PROCEDURE NOT ON FILE
1030	4TH SURGICAL PROCEDURE NOT FOUND
1031	5TH SURGICAL PROCEDURE NOT FOUND
1032	6TH SURGICAL PROCEDURE NOT FOUND

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
1033	FIRST SURGERY DATE (FIELD 80) NOT WITHIN (STATEMENT COVERS PERIOD) DATE SPAN (FIELD 6)
1034	SECOND SURGERY DATE (FIELD 81) NOT WITHIN (STATEMENT COVERS PERIOD) DATE SPAN (FIELD 6)
1036	4TH SURGERY DATE/STAY CONFLICT
1037	FACILITY PROVIDER ID NOT ON FILE
1038	5TH SURGERY DATE/STAY CONFLICT
1039	6TH SURGERY DATE/STAY CONFLICT
1043	CLAIM HAS BEEN REVIEWED. REFER TO EOB CODES 1901 - 1940 FOR DENIAL REASON.
1050	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER
1052	DEPT OF HEALTH LICENSE NUMBER IS MISSING
1053	TAXONOMY CODE INVALID FOR PERFORMING PROVIDER
1054	DPR NUMBER IS NOT ON FILE
1055	DTL REFERRING PROV NOT ON FILE
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM
1059	THIS SERVICE IS NOT A VALID ENCOUNTER UNLESS BILLED BY THE PCP/CM
1060	NO RENDERING PROVIDER FOR CROSSOVER CLAIM
1061	FILE INDICATES YOU ARE ENROLLED AS AN IN-STATE, NON-PARTICIP PROVIDER. CLAIM WAS REVIEWED. SRVS DEEMED NON-EMERGENCY AND NON-COVERED.
1062	FIRST SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
1063	SECOND SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
1064	THIRD SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
1065	4TH SURGICAL PROCEDURES/SEX CONFLICT
1066	5TH SURGICAL PROCEDURES/SEX CONFLICT
1067	6TH SURGICAL PROCEDURES/SEX CONFLICT
1069	PROVIDER NOT AUTHORIZED TO TAPE BILL
1070	FIRST SURGICAL PROCEDURE CODE NOT ON FILE
1071	SECOND SURGICAL PROCEDURE NOT ON FILE
1072	THIRD SURGICAL PROCEDURE NOT ON FILE
1073	4TH SURGICAL PROCEDURE NOT FOUND
1074	5TH SURGICAL PROCEDURE NOT FOUND
1075	6th SURGICAL PROCEDURE NOT FOUND
1076	PROVIDER TYPE NOT ON TPL MATRIX
1077	RECIPIENT IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE
1079	DIAGNOSIS NOT SPECIFIC
1080	RECIPIENT SEX ON FILE INCOMPATIBLE W/PRIMARY DIAG - IF BABY AND MOTHER INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
1081	RECIPIENT SEX ON FILE INCOMPATIBLE W/PRIMARY DIAG - IF BABY AND MOTHER INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
1082	THIRD DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
1083	FOURTH DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
1084	FIFTH DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
1085	CLAIM MUST BE PROCESSED THROUGH THE PSN
1086	CLAIM MUST BE PROCESSED THROUGH PSN
1090	1ST SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
1091	2ND SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
1092	3RD SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
1093	4TH SURGICAL PROCEDURE DATE INVALID
1094	5TH SURGICAL PROCEDURE DATE INVALID
1095	6TH SURGICAL PROCEDURE DATE INVALID
1096	OCCUR SPAN TO DATE MISSING
1097	OCCURRENCE SPAN FROM DATE MISSING
1098	MISSING OCCURRENCE SPAN CODE AND DATES
1099	OCCUR SPAN FROM DATE MISSING
1100	REFERRING PROVIDER NUMBER REQUIRED

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
1101	OCCUR SPAN FROM DATE MISSING
1102	NURSING HOME PROVIDER NOT ALLOWED TO BILL REVENUE CODES
1103	MID-MONTH RATE CHANGE
1106	THIS GLOBAL CPT-4 PROCEDURE HAS BEEN ADDED TO MORE ACCURATELY REFLECT THE SERVICE PERFORMED. THE BILLED AMOUNT FOR THIS PROCEDURE WAS CALCULATED.
1112	DETAIL DENIED. THE PROCEDURE BILLED HAS BEEN REBUNDLED TO A GLOBAL CPT-4 CODE THAT MORE ACCURATELY REFLECTS THE SERVICE THAT WAS PERFORMED.
1129	DETAIL DENIED. PROCEDURE BILLED WAS PERFORMED WITH A PRIMARY PROCEDURE. IT IS CONSIDERED PART OF PRIMARY PROC.
1130	OCCUR SPAN TO DATE MISSING
1131	OCCUR SPAN TO DATE MISSING
1132	OCCURRENCE SPAN TO DATE IS MISSING
1136	RECIPIENT AGE ON FILE INCOMPATIBLE W/PRIMARY DIAG - IF BABY AND MOTHER INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
1137	RECIPIENT AGE ON FILE INCOMPATIBLE W/2ND DIAG - IF BABY AND MOTHER INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
1138	THIRD DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
1139	FOURTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
1140	FIFTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
1143	KICK PAY-TO-PROVIDER AND SERV PROV ERR
1144	PROCEDURE NOT COMPATIBLE WITH PROV TYPE, PROCEDURE CANNOT BE BILLED ON THE CLAIM FORM USED OR NEW ANESTH CODE CONFLICTS WITH MODIFIER OR DOS
1145	FIRST DIAGNOSIS CODE NOT COVERED
1146	SECOND DIAGNOSIS CODE NOT COVERED
1147	THIRD DIAGNOSIS CODE NOT COVERED
1148	FOURTH DIAGNOSIS CODE NOT COVERED
1149	FIFTH DIAGNOSIS CODE NOT COVERED
1150	PROV/PROC CODE MODIFIER/PLACE OF SERV CONFLICT. POST WITH ASC MOD 73 OR 74
1152	CREDIT/ADJUSTMENT REQUIRES TCN
1153	NO MATCH ON RECIPIENT ID
1154	NO MATCH ON PROVIDER NUMBER
1155	CLAIM HAS ALREADY BEEN CREDITED/ADJUSTED
1156	ELECTRONIC ADJUSTMENT/VOID ADJUSTING A DENIED CLAIM
1157	CLAIM NOT ON HISTORY
1158	CANNOT ADJUST A CREDIT
1159	FIRST DIAGNOSIS IS SUB-CLASSIFIED
1160	SECOND DIAGNOSIS IS SUB-CLASSIFIED
1161	THIRD DIAGNOSIS IS SUB-CLASSIFIED
1162	FOURTH DIAGNOSIS IS SUB-CLASSIFIED
1163	FIFTH DIAGNOSIS IS SUB-CLASSIFIED
1164	SIXTH DIAGNOSIS IS SUB-CLASSIFIED
1165	SEVENTH DIAGNOSIS IS SUB-CLASSIFIED
1166	EIGHTH DIAGNOSIS IS SUB-CLASSIFIED
1167	NINTH DIAGNOSIS IS SUB-CLASSIFIED
1168	10TH - 24TH DIAGNOSIS IS SUB-CLASSIFIED
1169	SIXTH DIAGNOSIS CODE NOT COVERED
1170	FIRST SURGICAL PROCEDURE NOT COVERED
1171	SECOND SURGICAL PROCEDURE NOT COVERED
1172	THIRD SURGICAL PROCEDURE NOT COVERED
1173	4TH SURGICAL PROCEDURE NOT COVERED
1174	5TH SURGICAL PROCEDURE NOT COVERED
1175	6TH SURGICAL PROCEDURE NOT COVERED
1176	FIRST SURGICAL PROCEDURE NOT BILLED
1177	SECOND SURGICAL PROCEDURE NOT BILLED
1178	THIRD SURGICAL PROCEDURE NOT BILLED

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
1179	4TH SURGICAL PROCEDURE NOT BILLED
1180	5TH SURGICAL PROCEDURE NOT BILLED
1181	6TH SURGICAL PROCEDURE NOT BILLED
1182	FIRST DIAGNOSIS CODE NOT BILLED
1183	SECOND DIAGNOSIS NOT BILLED
1184	THIRD DIAGNOSIS CODE NOT BILLED
1185	FOURTH DIAGNOSIS CODE NOT BILLED
1186	FIFTH DIAGNOSIS CODE NOT BILLED
1187	SIXTH DIAGNOSIS CODE NOT BILLED
1200	PAY TO PROVIDER NUMBER IS NOT A GROUP
1201	PAY TO PROVIDER IS INACTIVE. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTIONS
1202	X-OVER CLAIM TYPE NOT ALLOWED FOR PROVIDER TYPE
1600	INVALID GROUP NUMBER
1601	TPL IS INDICATED ON FILE, BUT DID NOT APPEAR ON CLAIM. YOUR CLAIM WAS DENIED AFTER AHCA REVIEW OF THE CLAIM AND ITS ATTACHMENT(S)
1602	TREATING PROVIDER IS A GROUP PROV
1603	PROVIDER NOT AUTHORIZED TO TAPE BILL
1901	ABORTION CERTIFICATE INVALID
1902	CONSENT FORM MISSING
1903	CONSENT FORM INCOMPLETE
1904	CONSENT FORM INVALID
1905	ACKNOWLEDGEMENT FORM MISSING
1906	ACKNOWLEDGEMENT FORM INVALID/INCOMPLETE
1907	INCIDENTAL PROCEDURE NOT COVERED
1908	PROCEDURE REQUIRES REVIEW REPORT
1909	CLAIM REQUIRES DOCUMENTATION
1910	PROCEDURE CODE/DESCRIPTION CONFLICT
1911	REPORT NOT ELIGIBLE
1912	DENIED AFTER MEDICAL REVIEW
1913	ABORTION CERTIFICATE MISSING
1914	HARD COPY CLAIM REQUIRED
1915	DIALYSIS STATEMENT MISSING
1916	INSUFFICIENT PRICING INFORMATION
1921	DENIED AT PROVIDERS REQUEST
1922	CLAIM BILLED WITH WRONG PROVIDER NUMBER
1923	NO RATE SHEET INCLUDED
1937	PERFORMING PROVIDER ID NOT ON FILE
1938	PRA FORM MISSING
1938	REFERRING PROVIDER NUMBER IS MISSING OR INVALID
1939	PRA FORM INVALID/INCOMPLETE
1941	OTHER PROVIDER ID NOT ON FILE
1950	PROCEDURE INCLUDED IN BUNDLED RATE
1951	HCPC IS REQUIRED
1990	OUT-STATE PROV NON-PARTICIPATING
1995	PERFORMING, FACILITY, DISPENSING PROV ID IN OLD FORMAT
1996	THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM
1997	THIS CLAIM WAS BILLED WITH AN OLD RENDERING PROV NUMBER. PLEASE RESUBMIT WITH AFTER AHCA REVIEW OF THE CLAIM AND ITS ATTACHMENT(S) THE CURRENT PROVIDER NUMBER.
1999	BILLING PROVIDER ID SUMITTED UNDER OLD FORMAT
2000	RECIPIENT HAS OPTED OUT OF MEDICAID COVERAGE
2001	SURGICAL PROCEDURE CONFLICTS WITH AGE LIMITATIONS
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE
2004	PROCEDURE INCLUDED IN COMBINED PROCEDURE
2005	NO CASH PAYMENT FOR HCBS

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2006	RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA
2007	PA NOT AUTHORIZED FOR DRUG THERCLASS 46 AND 47
2008	EXCEEDS EMERGENCY ROOM VISITS FOR THIS DATE
2009	MEMBER INELIGIBLE ON DATE OF SERVICE
2010	NEWBORN OCCURRENCE CODE MISSING. WHEN ADMIT AND BIRTH DATES ARE EQUAL AND THE NEWBORNS LENGTH OF STAY EXCEEDS THE MOTHERS - USE OCCUR CODE 42.
2011	MATERNITY CLINIC/PHY CONFLICT FOR PRENATAL SERVICE
2012	MAXIMUM CRITICAL CARE VISITS EXCEEDED
2013	EXCEEDS 9 MO LIMIT FOR THIS LEVEL PRENATAL CARE
2014	EXCEEDS MONTHLY CLINIC VISIT LIMITS
2015	SCHOOL BASED YEARLY LIMIT EXCEEDED
2016	LIMIT OF HH VISITS HAS BEEN EXCEEDED FOR 1 YEAR
2017	LIMIT FOR CHMC SERVICE HAS BEEN EXHAUSTED
2018	DIABETIC SUPPLIES LIMITS EXCEEDED
2019	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2020	YEARLY LIMIT FOR EYE GLASSES EXCEEDED
2021	12 MONTH LIMIT FOR THIS DENTAL SERVICE IS EXCEEDED
2022	A CONFLICTING SERVICE HAS BEEN PAID FOR THIS DATE
2023	DEALER LIMITS EXCEEDED
2024	OTHER FED QUAL HEALTH CENTER SERV PAID THIS DATE
2025	EXCEEDS EARLY INTERVENTION SERVICES LIMITS
2026	EXCEEDS EPSDT CLINIC LIMITS
2027	EXCEEDS OB ULTRASOUND LIMIT FOR 9 MONTHS
2028	EXCEEDS NUTRITIONAL SERVICE FOR YEAR
2029	EXCEEDS HOME COM BASED WAIVERED SERVICE LIMITS
2030	SAME SERV WITH 91/92 HCPC HAS BEEN PAID THIS DATE
2031	EXCEPTION CODE 031
2032	MAXIMUM RENTAL PAYMENT
2033	HIGHER CEREBRAL FUNCTION PREVIOUSLY PAID IN 12 MTS
2034	EXCEEDS YEARLY EARLY INTERVENTION CASE MAN LIMITS
2035	THE 2 PHY VISIT PER MONTH LIMIT HAS BEEN EXCEEDED
2036	ADDITIONAL HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION
2037	MAXIMUM PAYMENT MADE
2038	EXCEEDS OXYGEN LIMITS-ONE PER MONTH
2039	TARGETED ULTRASOUND/AMNIOCENTESIS REVIEW
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED
2041	EXCEPTION CODE 041
2042	EXCEEDS ONCE PER MONTH LIMIT
2043	ONE NEWBORN EXAM HAS BEEN PAID FOR THIS CHILD
2044	PREVIOUSLY PAID-VISIT OR W3011-THIS DATE OF SERV.
2045	EXCEPTION CODE 045
2046	EXCEPTION CODE 046
2047	EXCEED PART A SKILLED NURSING FACILITY COINS LIMIT
2048	CONFLICTING DENTAL SERVICE SAME DAY
2049	EXCEEDS PSYCHOLOGICAL LIMIT PER MONTH
2050	EXCEPTION CODE 050
2051	EXCEEDS 2 VISIT LIMIT
2052	NO LTC STAFFING SUBMITTED FOR SERVICE MONTH
2053	LTC EMC CLAIM INVALID WHEN STAFFING IS SENT PAPER
2054	PCS INELIGIBLE FOR CATEGORY OF SERVICE
2055	2 RURAL HEALTH VISITS PER MONTH HAS BEEN EXCEEDED
2056	TRIGGER POINT INJECTION LIMIT HAS BEEN EXCEEDED
2057	OUTPATIENT MENTAL HEALTH LIMITS EXCEEDED
2058	YEARLY ASSISTATIVE TECHNOLOGY LIMIT EXCEEDED
2059	EXCEPTION CODE 059

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2060	EXCEPTION CODE 060
2061	EXCEPTION CODE 061
2062	EXCEPTION CODE 062
2063	EXCEPTION CODE 063
2064	EXCEPTION CODE 064
2065	EXCEPTION CODE 065
2066	EXCEPTION CODE 066
2067	EXCEPTION CODE 067
2068	EXCEPTION CODE 068
2069	EXCEPTION CODE 069
2070	2 NURSING HOME VISITS PREVIOUSLY PAID THIS MONTH
2071	THIS SERV HAS BEEN PREVIOUSLY PAID FOR THIS MEMBER
2072	PREVIOUSLY PAID VISUAL EXAM IN 12 MONTHS
2073	EXCEPTION CODE 073
2074	PREVIOUSLY PAID 3 PAP SMEARS IN 12 MONTHS
2075	EXCEPTION CODE 075
2076	EXCEEDS YEARLY FAMILY PLANNING EXAM LIMIT
2077	EXCEPTION CODE 077
2078	PREVIOUSLY PAID ONE VISIT ON THIS DAY
2079	EXCEPTION CODE 079
2080	PREVIOUSLY PAID AUDITORY EXAM IN 12 MONTHS
2081	CHILDRENS DAYS EXCEEDED
2082	CHILDRENS DAYS EXHAUSTED
2083	CHILDRENS VISITS EXCEEDED
2084	CHILDRENS VISITS EXHAUSTED
2085	CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED
2086	CHILDREN DAYS EXCEEDED FOR FISCAL YEAR PA REQUIRED
2087	TB DRUG
2088	EXCEPTION CODE 088
2089	EXCEPTION CODE 089
2090	PCS - 1500
2091	RECIPIENT SERVICES COVERED BY HMO PLAN
2092	ALIEN-NO REQUEST FOR AUTHORIZATION RECEIVED
2094	PROVIDER SPECIALTY REQUIRES THE BENEFICIARY BE ELIGIBLE FOR WAIVER RELATED PROC
2095	REVIEW INVALID CARRIER DENIED BATCH
2096	DDSD HAS DENIAL/SUSPEND EDIT
2097	COVERED IN PER DIEM
2098	HCBW WAIVER HAS DENY/SUSPEND EDIT
2099	MANUALLY SUSPEND FOR HCA
2100	RECIPIENT INELIGIBLE FOR MEDICAID ONLY SERVICES
2101	ADP WAIVER HAS DENY/SUSP EDIT
2103	PROCEDURE NOT COVERED WITH THIS PLACE OF SERVICE
2104	INVALID PROVIDER SPECIALTY FOR PROCEDURE
2105	INVALID DIAGNOSIS FOR PROCEDURE
2106	MEMBER NAME IS MISSING
2110	PCS CLAIM - MEMBER NOT PCS ELIGIBLE
2112	MISSING TOTAL CHARGE FOR NURSING HOME CLAIMS
2114	OUTPT HSP PRIOR TO 12/01/99-SUSPEND FOR REVIEW
2115	VISIT WITHIN NORMAL SURGERY FOLLOW-UP PERIOD
2116	EXCEPTION CODE 116
2117	2 YEAR RESUBMISSION DEADLINE EXCEEDED
2118	DISCHARGE DATE IS LESS THAN ADMIT DATE
2119	DISCHARGE DATE IS LESS THAN LAST DATE OF SERVICE
2120	VISIT PAID IN NORMAL SURGERY FOLLOW-UP PERIOD
2121	CLAIM WAS FILED WITHOUT SERVICING PROVIDER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2122	INVALID/MISSING PROVIDER CHECK-DIGIT NUMBER
2123	INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER
2124	MISSING FIRST DATE OF SERVICE ON CLAIM
2125	ONE YEAR TIMELY FILING DEADLINE EXCEEDED-FED REG
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
2127	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV
2128	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV
2129	MISSING MEMBER ID NUMBER ON CLAIM
2130	EXCEPTION CODE 130
2132	MISSING TOTAL CLAIM CHARGE
2133	INVALID TOTAL CLAIM CHARGE
2134	INVALID NET CLAIM CHARGE
2136	MISSING/INVALID REVENUE CODE
2138	MISSING/INVALID TYPE OF BILL
2140	HCPC CODE IS INVALID FOR REVENUE CODE
2141	TOTAL DAYS LESS THAN COVERED DAYS
2142	1 YR TIMELY FILE HAS BEEN OVERRIDDEN-TF ATTACHED
2143	REFILLS EXHAUSTED
2144	INVALID REFILL INDICATOR VALUE
2146	HCPC/REVENUE CODE MISSING
2148	PROCEDURE NOT PAYABLE THIS MEMBER
2149	PROC REQUIRES REVIEW CATEGORICALLY NEEDY MEMBER
2150	UNITS OF SERVICE ARE LESS THAN PROC ALLOWED UNITS
2151	MISSING PRESCRIBING PROVIDER NUMBER
2152	MISSING DRUG CODE
2153	INVALID DRUG CODE
2154	MISSING PRESCRIPTION NUMBER
2155	MISSING DRUG QUANTITY
2156	MISSING DAYS SUPPLY
2160	MISSING DIAGNOSIS INDICATOR
2163	MISSING DIAGNOSIS CODE
2166	MEMBER ELIGIBILITY PENDING DHS APPROVAL
2167	INVALID PATIENT STATUS
2168	INVALID SOURCE OF ADMISSION
2170	INVALID PLACE OF SERVICE
2172	CLAIM REQUIRES HCPC OR CPT-4 CODE
2173	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE
2174	UNITS CANNOT BE LESS THAN DAYS
2175	SURGICAL PROCEDURE MISSING
2176	MEMBER NOT ON FILE PAY FROM STATE FUNDS
2178	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2179	MISSING TOOTH SURFACE
2180	INVALID TOOTH NUMBER
2181	INVALID TOOTH SURFACE
2182	MISSING TOOTH NUMBER
2183	MISSING UNITS OF SERVICE
2184	MISSING CHARGE
2185	LTC MISSING ADMISSION DATE
2186	INVALID ADMISSION HOUR
2187	PROCEDURE NOT PAYABLE THIS MEMBER
2189	PROCEDURE REQUIRES MEDICAL REVIEW
2190	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2191	ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM
2192	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN
2193	MISSING COVERED DAYS

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2194	AGE IS NOT COVERED INPATIENT PSYCHIATRIC SERVICES
2196	MISSING ADMISSION DATE
2197	INVALID INPATIENT REVENUE CODE
2198	MISSING ATTENDING SURGEON PRESCRIBER NUMBER
2199	DATE OF SURGERY IS MISSING
2200	INVALID TYPE OF ADMISSION
2201	PROCEDURE CODE IS NOT IN THE SCOPE OF PROGRAM
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE
2203	CLAIMANT SIGNATURE MISSING
2204	PROVIDER SIGNATURE IS MISSING
2205	PATIENT NOT CERTIFIED
2206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT
2207	INVALID LEVEL OF CARE
2208	INVALID PICKUP LOCATION
2209	INVALID DESTINATION
2210	FACILITY PROVIDER SERVICE LOCATION IS MISSING
2213	PREGNANCY INDICATOR INVALID
2214	DATE PRESCRIBED IS INVALID
2215	DATE DISPENSED IS MISSING
2216	DATE DISPENSED IS INVALID
2222	MISSING OCCURRENCE DATE
2223	SERVICE DATES ARE NOT IN SAME MONTH
2224	INVALID OCCURRENCE DATE
2226	INVALID CONDITION CODE
2227	EXCEPTION CODE 227
2228	MISSING MEDICARE PAID DATE
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
2231	ESTIMATED DAYS SUPPLY INVALID
2233	INSURANCE DENIAL REQUIRED
2234	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2235	SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE
2236	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE
2237	FACILITY PROVIDER NOT IN VALID FORMAT
2238	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2239	INVALID OCCURRENCE CODE
2240	THE DETAIL LINE (TO) DATE OF SERVICE IS MISSING
2241	XOVER DATA MISSING AT DETAIL LEVEL
2242	MISSING OCCURRENCE CODE
2244	INVALID PAY-TO PROVIDER NUMBER
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
2249	CLAIM HAS NO DETAILS
2250	MEMBER IS NOT ON ELIGIBILITY FILE
2252	MEMBER IS NOT ELIGIBLE ALL DATES OF SERVICES
2253	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2254	MEMBER NOT IN MANAGED CARE
2258	MEMBER IS NOT ON ELIGIBILITY FILE
2259	DATE BILLED IS INVALID
2260	SLIMB ONLY/NO MEDICAL ELIGIBILITY
2262	PROCEDURES NOT PAYABLE TB
2263	PROCEDURE REQUIRES REVIEW FOR TB MEMBER
2265	CLAIM HAS THIRD-PARTY PAYMENT
2266	REFERRING PHYSICIAN NUMBER IS MISSING
2268	INVALID PER DIEM AMOUNT
2270	INPATIENT TB NOT COVERED
2271	MEMBER IS NOT ELIGIBLE ON SERVICE DATE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2272	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN
2273	SUSPENDED FOR MEMBER REVIEW
2274	CLAIM INDICATES MEMBER EXPIRED
2276	NEWBORN-HCA REVIEW
2277	LTC ELIGIBILITY ERROR
2278	DISCHARGE DTE UNEQ TO LTC ELIG
2281	ABORTION NOT COVERED
2282	PHYSICIAN AUDITOR REVIEW-MODIFIER 24
2285	MEMBER NOT ELIGIBLE FOR DATES OF SERVICE
2287	PROCEDURE NOT PAYABLE VR
2289	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2290	PROCEDURE IS NOT IN THE SCOPE OF THE PROGRAM
2291	PROCEDURE REQUIRES MEDICAL REVIEW
2292	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2294	PROC REQUIRES REVIEW - HCBW
2295	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2296	PROVIDER INELIGIBLE FOR PROCEDURES
2297	PAY TO PROVIDER NOT ELIG FOR PAY-THIS DATE OF SERV
2298	PROVIDER NUMBER IS A GROUP NUMBER
2300	NO PROVIDER MASTER RECORD
2302	DPR NUMBER IS NOT ON FILE
2303	PROVIDER IS SUSPENDED OR TERMINATED FOR PROGRAM BILLED
2304	PROVIDER INELIGIBLE ON SERVICE DATE
2305	REVIEW CLAIMS FOR THIS PROVIDER
2306	PAY TO PROVIDER IS SUSPENDED
2307	BILLING OUT OF CLIA CERTIFICATE TYPE
2308	NO PAY-TO PROVIDER RECORD
2309	REVIEW CLAIM FOR PAY-TO- PROVIDER
2310	ANESTHESIA MODIFIER IS INVALID OR MISSING
2311	SERVICING PROVIDER IS NOT A MEMBER OF PAY TO GROUP
2312	PAY-TO PROVIDER NOT ENROLLED
2313	DIAGNOSIS CODE MISSING/NOT ON FILE
2314	SURGICAL PROCEDURE CODE NOT FOUND
2315	INVALID PRINCIPAL/OTHER PROCEDURE TYPE
2317	PROCEDURE CODE/MODIFIER CONFLICT
2318	PROCEDURE REQUIRES MANUAL PRICING
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED
2321	PROCEDURE CODE IS NO LONGER VALID
2322	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE
2323	INVALID MEMBER AGE FOR THIS DIAGNOSIS
2324	INVALID MEMBER SEX FOR THIS DIAGNOSIS
2326	INVALID TOOTH NUMBER FOR THIS PROCEDURE
2327	PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION
2328	PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE
2329	INVALID MEMBER SEX FOR THIS PROCEDURE
2331	THIS DRUG NOT COVERED FOR THE MEMBER
2332	INVALID PROVIDER TYPE FOR THIS PROCEDURE
2335	LTC MEMBER - NONCOMP DRUG
2336	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS
2337	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2338	LTC DRUG ONLY
2341	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2342	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2345	ATTENDING PROVIDER NOT FOUND
2346	REFERRING PROVIDER NUMBER NOT ON FILE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2347	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2348	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW
2350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT
2351	SUBMITTED TO ALLOWED EXCEEDS PERCENT
2352	ALLOWED TO SUBMITTED EXCEEDS PERCENT
2354	THIS LAB NOT CERTIFIED TO PROVIDE THIS SERVICE
2356	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
2357	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2358	INACTIVE DRUG
2359	THIS DRUG REQUIRES PRIOR AUTHORIZATION
2360	THIS NATIONAL DRUG CODE IS NOT ON FILE
2361	PROCEDURE CODE IS MISSING/NOT ON FILE
2362	MEDICARE DEDUCTIBLE GREATER THAN MAXIMUM
2366	THIS DIAGNOSIS REQUIRES REVIEW
2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID
2371	THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION
2372	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY
2374	MISSING PRESCRIBER PROVIDER ON DEALER CLAIM
2375	SERVICE NOT ON EXPLANATION OF MEDICARE PAYMENTS
2377	MEMBER IS INELIGIBLE FOR THIS DRUG
2379	PROCEDURE CODE MODIFIER REQUIRES MANUAL REVIEW
2383	MULTIPLE SURGERY REQUIRES REVIEW
2385	REVENUE CODE NOT ON FILE
2388	IMPROPER MODIFIER FOR CRNA
2389	THIS MODIFIER IS ALLOWED FOR CRNA ONLY
2390	MULTIPLE EXTRACTION REQUIRES APPROPRIATE PROC CODE
2391	INVALID USE OF E DIAGNOSIS CODE
2394	VERIFY PCS TPL
2396	LOC ON CLAIM CONFLICTS WITH LOC ON FILE
2397	INVALID LTC TERMINATION CODE
2399	REFERRING PROVIDER ID IS NOT IN A VALID FORMAT
2400	INVALID LOC DAYS
2401	INVALID LEAVE DAYS
2402	INVALID TYPE OF LEAVE
2406	LTC LEAVE DATES CONFLICT
2407	THERAPEUTIC DAYS GT THAN 14
2410	PA IS REQUIRED
2411	THERAPEUTIC DAYS USED EXCEEDS AUTHORIZATION
2412	DETAIL DENIED. ONLY ONE DATE OF SERVICE ALLOWED PER DETAIL.
2413	LTC BLOCK 13: TOTAL DAYS DO NOT EQUAL FROM/TO DAYS
2414	WAIVER SERVICES LONG TERM CARE CONFLICT
2416	AMB SERVICES ORIGIN TO DESTINATION NOT IN SCOPE
2417	REVIEW AMBULANCE NON ROUTINE DESTINATION
2420	THIS DRUG NOT PAYABLE FOR MEMBER AGE
2421	THIS DRUG NOT PAYABLE FOR MEMBER SEX
2425	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE
2430	LTC INVALID MEMBER ID NUMBER
2431	LTC NO PROV MASTER RECORD
2433	LTC MISSING PROVIDER NUMBER
2434	LTC INVALID PROV NUM CK-DIGIT
2435	LTC FIRST DATE OF SERVICE MISSING
2436	LTC FILING DEADLINE EXCEEDED
2437	LTC FIRST DATE GREATER LAST DATE
2438	LTC RECHECK SERVICE DATE
2439	LTC MISS MEMBER ID NUMBER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2440	TEST - NO PRICING SEGMENT ON FILE
2443	LTC MEMBER NOT ON ELIG FILE
2444	LTC MEMBER INELIGIBLE ON SERVICE DATES
2445	LTC MEMBER NOT ELIGIBLE ON SERVICE DATES
2446	LTC MEMBER SUSPEND FOR REVIEW
2447	LTC PROV IS SUSPENDED
2448	LTC PROVIDER IS INELIGIBLE ON SERVICE DATES
2449	LTC REVIEW CLAIM FOR PROV
2450	INVALID QUADRANT
2451	LTC INV PROVIDER NUMBER
2452	RENDERING PROVIDER SERVICE LOCATION IS MISSING
2453	INVALID DIAGNOSIS TREATMENT INDICATOR
2454	INVALID ASSIGNMENT CODE
2456	INVALID PROCEDURE TYPE
2458	ALIEN MEMBER ON REVIEW
2459	REVENUE CODES OP401 AND OP403 NEED HCPC CODE
2460	CANNOT DETERMINE THE INPATIENT LEVEL OF CARE
2461	OCCURENCE CODE SPAN MISSING/INVALID
2462	INVALID/MISSING SPAN DATE
2463	SPAN THRU DATE LESS THAN SPAN FROM DATE
2464	SPAN DATE CONFLICT WITH DATES OF SERVICE SHOWN
2465	SPAN DATES OVERLAP
2466	SPAN DATES DOES NOT EQUAL TOTAL LINE ITEM DAYS
2468	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2469	LTC MEMBER NAME/ID MISMATCH
2470	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2471	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
2472	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2473	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
2474	DATE DISPENSED AFTER BILLING DATE
2475	DATE DISPENSED AFTER ICN DATE
2476	MAXIMUM HOSPITAL DAYS FOR THIS ADULT HAS BEEN PAID
2477	THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT
2478	PCS MISSING SUBMITTED CHARGE
2479	CLIA OUT OF DATE
2480	DDSD/NFM PROVIDER-NOT DDSD/NFM MEMBER
2481	DDSD/NFM PROCEDURE - NOT DDSD/NFM MEMBER
2482	DDSD/NFM PROCEDURE - NOT DDSD/NFM PROVIDER
2483	DDSD/NFM PROVIDER - NOT DDSD/NFM PROCEDURE
2484	DDSD SERVICE REQUIRES PRIOR AUTHORIZATION
2485	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
2486	INPATIENT PSYCHIATRIC NEEDS PRIOR AUTHORIZATION
2487	PRIMARY DIAG CODE DETOX/NO DETOX REVENUE CODE
2488	ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE
2489	NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE
2490	INPATIENT SERVICES ARE NOT COVERED FOR THIS MEMBER
2491	DRUG NOT APPROVED
2492	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2493	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2494	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2495	NO CLIA - DOS PRIOR TO CLIA EFFECTIVE DATE
2496	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2497	NO CLIA - DOS PRIOR TO CLIA - EFFECTIVE DATE
2498	NO CLIA-DOS PRIOR TO CLIA EFFECTIVE DATE
2499	TPL PAY CHASE IMMUNO SUPPRESS DRUG

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2500	TPL - PAY AND REPORT
2501	SUSPEND FOR TPL REVIEW
2502	FILE CLAIM WITH MEDICARE
2503	THIS PATIENT HAS OTHER INSURANCE
2505	CLAIM DOCUMENTATION INDICATES OTHER INSURANCE PAYMENT WAS RECEIVED BY MEMBER OR IS NOT SUFFICIENT
2507	EPSDT-MAY HAVE TPL
2508	TPL PAY AND CHASE PHARMACY
2509	TPL PAY AND CHASE PRE-NATAL
2510	THIS PATIENT HAS TWO COVERAGE TYPES
2516	PROVIDER TYPE NOT ON TPL MATRIX
2517	TPL ON RECIPIENT FILE, NOT ON CLAIM (PAY CLAIM)
2518	PROVIDER TYPE - CLAIM INPUT CONFLICT
2519	DRUG REQUIRES PRIOR AUTHORIZATION
2520	DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED
2521	TPL ON RECIPIENT FILE, NOT ON CLAIM (PAY AND LIST)
2522	MEMBER IS NOT ELIGIBLE FOR THESE SERVICES
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE
2526	PCS PRIOR AUTHORIZATION NOT ON FILE
2527	PCS-NO UNITS AUTHORIZED-THESE DATES OF SERVICES
2528	PCS PRIOR AUTHORIZATION UNITS USED
2530	TIER 2 NSAID NO RECORD OF TIER ONES ON FILE
2532	DISEASE STATE MANAGEMENT
2534	PRODUR DRUG-AGE INTERACTION
2535	PDUR INGREDIENT DUPLICATION
2536	PDUR THERAPEUTIC DUPLICATION
2537	PDUR DRUG-TO-DRUG INTERACTION
2538	HMO CO-PAY/MEMBER HAS TPL
2539	PDUR EARLY REFILL ON PRESCRIPTION
2540	PDUR MINIMUM DURATION OF THERAPY
2541	PDUR DOSING PRECAUTION-HIGH DOSE
2542	PDUR DOSING PRECAUTION-LOW DOSE
2543	PDUR BREAST FEEDING/PREGNANCY PRECAUTION
2544	PDUR MAXIMUM DURATION OF THERAPY
2545	PDUR LATE REFILL ON PRESCRIPTION
2546	DRUG DISEASE MARKER
2547	HMO CO-PAY/MEMBER HAS MEDICARE
2548	PAY TO PROV FOR PROVIDER TYPE 63 MUST BE GROUP
2549	ADJUSTMENT SUSPEND FOR MANUAL REVIEW
2550	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER
2552	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE/MEDICAID
2555	CLAIM PAST 24 MONTH FILING - DTL
2556	MEMBER IS NOT WAIVER ELIGIBLE
2557	CLAIM PAST 24 MONTH FILING - HDR
2560	MEMBER SERVICES COVERED BY HMO PLAN
2561	PROVIDER INELIGIBLE FOR T19 SERVICES/HMO ONLY
2562	MEMBER PCPCM-CANNOT BILL OP/RHC/FOHC CLINICS RATE
2563	MEMBER NOT ENROLLED IN HMO FOR DOS
2564	SUPPLEMENTAL DELIVERY PYMT DENIAL CODE
2566	EXCEPTION CODE 566
2567	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE
2569	CC CLAIMS CAN NOT PROCESS THRU SYSTEM
2570	INVALID ELIGIBILITY FOR HMO COPAY
2571	CLAIMCHECK REBUNDLED
2572	CC INCIDENTAL TO PRIMARY PROCEDURE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2573	CC MUTUALLY EXCLUSIVE
2574	CLAIMCHECK COSMETIC SURGERY
2575	CLAIMCHECK DUPLICATE
2576	CC UNLISTED/OBSOLETE/EXPERIMENTAL/UNSPECIFIED
2577	CLAIMCHECK POSSIBLE DUPLICATE
2578	CLAIMCHECK PRE-OP/POST-OP
2579	CC GROUPEALTH SMARTSUSPENSE SUSPEND
2580	CLAIMCHECK MEDICAL/EVALUATION VISIT
2581	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN
2582	MEMBER IS LOCKED-IN TO ANOTHER PHARMACY
2583	CLAIMREVIEW NEW VISIT FREQUENCY
2584	CC GROUPLHTH SMARTSUSPENSE DENY
2587	CLAIMREVIEW INTENSITY OF SERVICE
2588	STOP LOSS NOT APPROVED
2589	CC INVALID MODIFIER/PROCEDURE COMBINATION
2590	CLAIMCHECK EXCEEDS 40 LINES
2591	CLAIMREVIEW MULTIPLE/DUPLICATE COMP BILLING
2592	CLAIMCEHCK AGE REPLACEMENT
2593	CLAIMREVIEW DIAGNOSIS TO PROCEDURE
2594	CLAIMCHECK-BILL EACH DOS ON A SEPARATE LINE
2595	CLAIMCHECK AGE CONFLICT
2597	CLAIMCHECK MULTIPLE SURGERY
2598	CC-MULTIPLE SURGERY-DOUBLE MODIFIERS
2599	STOP LOSS THRESHOLD REACHED
2600	UNITS NOT EQUAL TO TEETH BILLED
2601	PART A CROSSOVER SPANS 20020501
2602	UNITS NOT EQUAL TO TEETH BILLED
2603	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2604	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2605	PRIOR AUTH FUND AND CLAIM FUND DOES NOT MATCH
2606	PRIOR AUTH UNITS/AMOUNTS USED
2609	CHECK CLAIM ATTACHMENT
2612	TOOTH NUM ON CLAIM DOES NOT MATCH TOOTH NUM ON PA
2614	DIAG CODE MISSING/NOT ON FILE-INPATIENT CLAIMS
2615	NO PROVIDER RATE FOR DATE OF SERVICE (MAY HAVE BEEN BILLED UNDER INCORRECT PROVIDER NUMBER)
2616	PROCEDURE NOT COMPENSABLE FOR ASSISTANT SURGEON
2618	AUTH SERVICES-MEMBER NOT ELIG
2619	MEMBER INELIGIBLE PAY (AUTH EXAM) FROM STATE FUND
2620	MEDICARE ADJUSTED CLAIM-SUBMIT PAPER XOVER CLAIM
2622	MASS CREDIT/ADJ BEING SUSPEND
2623	THE CLAIM WAS CREATED BY A MASS ADJUSTMENT OR A MASS CREDIT
2625	FUND CODE UNDETERMINED
2627	COVERED FOR ORAL PATH ONLY
2628	DRUG REQUIRES PRIOR AUTHORIZATION/MN
2630	DIAGNOSIS NOT IN SCOPE OF DCYS PROGRAM
2631	DIAGNOSIS NOT IN SCOPE OF CCP PROGRAM
2632	DIAGNOSIS NOT IN SCOPE OF CN PROGRAM
2633	DIAGNOSIS NOT IN SCOPE OF MN PROGRAM
2634	DETAIL ATTENDING PHYSICIAN ID INVALID
2635	DETAIL FIRST OTHER PHYSICIAN ID INVALID
2636	DETAIL SECOND OTHER PHYS ID INVALID
2638	DRUG REQUIRES MEDICAL REVIEW/CN
2639	DRUG REQUIRES MEDICAL REVIEW/MN
2642	INVALID PROVIDER NUMBER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2643	ABORTION REQUIRES REVIEW
2644	PROCEDURE CODE MODIFIER NOT PAYABLE
2646	PROVIDER RATE NOT ON FILE
2648	CC SITE SPECIFIC MODIFIER-FILE ON SEPARATE LINE
2649	FILE SEPARATE CLAIMS FOR JUNE/JULY HOSPITAL DAYS
2651	INVALID TREATMENT DIAGNOSIS INDICATOR
2652	PCS-INVALID NET CLAIM CHARGE
2653	MEMBER ID IS INVALID FOR AUTH EXAM
2654	MEMBER ID IS INVALID FOR AUTH EXAM PAY STATE FD
2655	ELIG CHANGES/FILE SEPARATE CLAIMS FOR EACH MONTH
2657	POTENTIAL DISABILITY CLAIM
2659	DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD
2660	ZERO AMOUNT TO PAY
2663	PCS-PROVIDER NUMBER IS NOT ON PROVIDER FILE
2664	PCS OVER 31 DAYS BILLED
2665	PCS MISSING PROVIDER NUMBER
2667	PCS-INVALID PROVIDER NUMBER CHECK DIGIT
2668	PCS MISSING FIRST DATE OF SERVICE
2669	PCS FILING DEADLINE EXCEEDED
2670	PCS FIRST DATE OF SERVICE GREATER THAN LAST DATE
2671	PCS SERVICE DATE IS GREATER THAN RECEIVED DATE
2672	PCS MISSING MEMBER NUMBER
2673	SUBMIT PAPER CLAIM
2674	PCS MISSING TOTAL CLAIM CHARGE
2675	PCS INVALID TOTAL CLAIM CHARGE
2676	PCS MEMBER NOT ON ELIGIBILITY FILE
2677	PCS MEMBER INELIGIBLE ON DATE OF SERVICE
2678	PCS ITEMIZED SERVICE DATE NOT IN MEMBER ELIG SPAN
2680	PCS PROVIDER IS SUSPENDED
2681	PROVIDER INELIGIBLE ON DATE OF SERVICE
2682	PCS REVIEW CLAIM FOR PROVIDER
2684	PCS INVALID PROVIDER NUMBER
2691	PCS-NO UNITS OF SERVICE
2696	CROSSOVER PART A NOT PAYABLE MEDICALLY NEEDY
2697	QMB MEMBER ELIGIBLE FOR CROSSOVER ONLY
2700	HCA FOR REVIEW
2701	PHYSICIAN SIGNED CONSENT FORM BEFORE STERILIZATION
2702	DATE OF SURGERY ON CONSENT FORM IS NOT ON CLAIM
2703	MEMBER UNDER 21 WHEN SHE SIGNED CONSENT FORM
2704	REQUIRES ADDRESS FOR FACILITY FOR STERILIZATION
2705	STERILIZATION CONSENT FORM IS NOT LEGIBLE
2706	DATE ON THE CONSENT FORM IS NOT LEGIBLE
2707	STERILIZATION/HYSTERECTOMY CONSENT FORM IS MISSING
2708	PATIENT NAME ON CONSENT FORM DOES NOT MATCH CLAIM
2709	CONSENT LESS THAN 30 DAYS BEFORE STERILIZATION
2710	CONSENT MORE THAN 180 DAYS BEFORE STERILIZATION
2711	STERILIZATION CONSENT FORM NOT DATED BY PHYSICIAN
2712	CONSENT FORM IS NOT SIGNED BY THE MEMBER
2713	CONSENT FORM IS NOT SIGNED BY THE COUNSELOR
2714	CONSENT FORM DOES NOT HAVE DATE COUNSELOR SIGNED
2715	STERILIZATION CONSENT FORM IS INCOMPLETE
2716	HYSTERECTOMY CONSENT FORM REQUIRED
2717	STERILIZATION CONSENT FORM NOT SIGNED BY PHYSICIAN
2718	INVALID SURGICAL PROCEDURE CODE
2719	REFILE CLAIM WITH OPERATIVE REPORT

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2720	INCORRECT MEMBER DATE OF BIRTH ON CONSENT FORM
2721	FURTHER DESCRIPTION OF SERVICE REQUIRED
2722	STRENGTH AND DOSAGE OF INJECTION MEDICATION REQ
2723	SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY
2724	REFILE CLAIM WITH CONSULTATION/PROGRESS NOTES
2725	SERVICE NOT COVERED AS BILLED
2726	REFERRING PHYSICIAN REQUIRED
2727	ANOTHER PROVIDER HAS BEEN PAID FOR THESE SERVICES
2728	SERVICES ARE NOT AUTHORIZED
2729	DENIED AFTER SPECIAL REVIEW
2730	HYSTERECTOMY CONSENT FORM SIGNED AFTER SURGERY
2731	HEALTH CARE AUTHORITY WILL PROCESS CLAIM
2732	COUNSELOR SIGNED CONSENT FORM PRIOR TO MEMBER
2733	SERVICES/SUPPLY NOT IN SCOPE OF PROGRAM
2734	PROCEDURE/REVENUE CODE-REQUIRE PRIOR AUTHORIZATION
2735	MEMBER INELIGIBLE ON SERVICE DATES
2736	MODIFIER ADDED/DELETED DUE TO MEDICAL REVIEW
2737	INVALID MODIFIER FOR THIS PROCEDURE
2738	INVALID PROCEDURE CODE USE VALID CPT OR HCPC CODE
2739	ONE AMBULATORY SURGERY ALLOWED PER DAY
2740	INVALID CODE FOR NARRATIVE DESCRIPTION
2741	INVALID SUBMITTED CHARGE
2742	AUTHORIZED PHYSICAL REQUIRES ABCDM-16
2743	EXCEPTION CODE 743
2744	AUTHORIZED PHYSICAL DOES NOT MATCH ABCDM-16
2745	REQUESTED ADDITIONAL INFORMATION NOT RECEIVED
2746	DENTAL X-RAYS ARE REQUIRED
2747	SERVICES ARE INCLUDED IN TOTAL PAID OB CARE
2748	PROCEDURE IS AN INCIDENTAL TO PAID MAJOR SURGERY
2749	OUTSIDE THE GUIDELINES OF THE MEDICAL PROGRAM
2750	EXCEEDS SUPPLY LIMIT/1 MONTH WITHIN 12 MONTHS
2751	EXCEPTION CODE 751
2752	PER PHY MANUAL-USE 99202 ANTEPART WHEN NOT TOTAL OB
2753	PROCEDURE IS INCIDENTAL MAJOR PROCEDURE ON CLAIM
2754	REFILE USING MEMBER AREA IN SQ CM
2755	REFILE CLAIM WITH PROOF OF TIMELY FILING ATTACHED
2756	EXCEPTION CODE 756
2757	TAKE HOME MEDICATION IS NOT PAYABLE
2758	PROVIDER NAME DOES NOT MATCH PROVIDER NUMBER
2759	NEEDS COUNTY ADMIN AND/OR PROVIDER SIGNATURE
2760	MEMBER IS DECEASED THIS DATE OF SERVICE
2761	NAME ON SUBMITTED CLAIM DOES NOT MATCH DHS FILE
2762	FILE AN ASSIGNED MEDICARE CLAIM ON THIS PATIENT
2763	PCS - HEALTH CARE AUTHORITY WILL PROCESS CLAIM
2764	DUPLICATE OF PAID CLAIM
2765	INVALID HYSTERECTOMY CONSENT FORM
2766	STERILIZATION/HYSTERECTOMY CONSENT FORM IS INVALID
2767	EXCEPTION CODE 767
2768	REQUEST ADJUSTMENT TO PAID CLAIM-PER MANUAL
2769	PAYMENT CORRECTED/SPENDDOWN-ADM12-HIST ONLY ADJUST
2770	INSURANCE PAYMENT MORE THAN ALLOWABLE
2771	SERVICE NOT PAYABLE THIS DATE OF SERVICE
2772	TYPE OF BILL-CLAIM CONFLICT
2773	AUTHORIZED ROOM AND BOARD SERVICES ARE NOT ON CLAIM
2774	EXCEPTION CODE 774

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2775	CLAIM HAS BEEN FORWARDED TO HCA
2777	SHOW MEDICARE PART B PAYMENTS
2778	HEALTH CARE AUTHORITY PROCESSED ADM12
2779	ELIGIBILITY PROBLEM PROCESSED BY DHS
2780	RESUBMIT WITH APPROPRIATE VALUE CODE AND UNITS
2781	ANOTHER DDS PAID THIS SERVICE IN PREVIOUS 12 MONTH
2782	PART OF INPATIENT HOSPITAL CHARGES
2783	PROCEDURE INCLUDED IN OFFICE CALL
2785	ANOTHER PHARMACY PAID FOR THIS PRESCRIPTION
2786	SAME NDC/DATE PAID THIS PHARM
2787	ASST SURGEON MUST FILE OWN CLM
2788	CLINIC VISIT PAID THIS DATE
2789	PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN
2790	ABCDM-16/CLAIM PROV CONFLICT
2791	INVALID DIAGNOSIS FOR DESCRIPTION
2792	STERILIZATION CONSENT REQUIRED
2793	SERVICE/SUPPLY INCLUDED IN AMBULANCE TRIP CHARGE
2794	PAID CLAIM INCLUDED THIS PROCEDURE
2795	CC MUTUALLY EXCLUSIVE
2796	PATIENT HAS PRIVATE INSURANCE
2797	MEMBER TB ELIG ONLY-CLAIM REQUIRES TB DIAGNOSIS
2798	REFILE WITH MEDICARE RECHECK HIC NUMBER
2799	EXCEPTION CODE 799
2800	PHARMACY-EXACT DUPLICATE OF ANOTHER CLAIM
2801	PHARMACY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2802	PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM
2803	DENTAL-EXACT DUPLICATE OF ANOTHER CLAIM
2804	DENTAL-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2806	PRACTITIONER-EXACT DUPLICATE OF ANOTHER CLAIM
2807	PRACTITIONER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2812	CROSSOVER-EXACT DUPLICATE OF ANOTHER CLAIM
2813	EXCEPTION CODE 813
2814	CROSSOVER-POSSIBLE CONFLICT OF ANOTHER CLAIM
2815	LTC-EXACT DUPLICATE OF ANOTHER CLAIM IN SYSTEM
2816	LTC-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2820	PCS-EXACT DUPLICATE OF ANOTHER CLAIM
2821	PCS-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2822	EXCEPTION CODE 822
2823	OUTPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2824	OUTPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2826	HOME HEALTH-EXACT DUPLICATE OF ANOTHER CLAIM
2827	EXCEPTION CODE 827
2828	HOME HEALTH-POSSIBLE CONFLICT OF ANOTHER CLAIM
2829	INPATIENT-EXACT DUPLICATE OF ANOTHER CLAIM
2830	INPATIENT-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2831	EXCEPTION CODE 831
2832	TRANSPORTATION-EXACT DUPLICATE OF ANOTHER CLAIM
2833	TRANSPORTATION-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2835	CHIROPRACTOR-EXACT DUPLICATE OF ANOTHER CLAIM
2836	CHIROPRACTOR-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2838	LAB/XRAY-EXACT DUPLICATE OF ANOTHER CLAIM
2839	LAB/XRAY-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2842	DEALER-EXACT DUPLICATE OF ANOTHER CLAIM
2843	DEALER-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2845	OPTOMETRIST-EXACT DUPLICATE OF ANOTHER CLAIM

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2846	OPTOMETRIST-POSSIBLE DUPLICATE OF ANOTHER CLAIM
2849	INVALID MODIFIER COMBINATION
2850	LTC/INPT POSSIBLE CONFLICT WITH INPT/LTC CLAIM
2851	LTC-HOME HEALTH CLAIM CONFLICT
2852	LTC-PCS POSSIBLE CONFLICT
2853	PCS-LTC POSSIBLE CONFLICT
2854	INPATIENT-PCS POSSIBLE CONFLICT
2855	PCS-INPATIENT POSSIBLE CONFLICT
2856	HH/INPT POSSIBLE CONFLICT WITH INPT/HH CLAIM
2857	HOSPICE TOTAL UNITS GREATER THAN TOTAL DAYS
2858	INPT/OUTPT POSSIBLE CONFLICT WITH OUTPT/INPT CLAIM
2859	EXCEPTION CODE 859
2860	CROSS CLAIM TYPE J CODE CONFLICT
2877	REVIEW EDITS 4005/4006/4009/4084 PRIOR TO CUTBACK
2880	PRODEDURE CODE NOT VALID FOR FORM
2881	HOME HEALTH-LTC CLAIM CONFLICT
2882	LTC/XOVER POSSIBLE CONFLICT WITH XOVER/LTC CLAIM
2883	CROSSOVER-PCS POSSIBLE CONFLICT
2884	PCS-CROSSOVER POSSIBLE CONFLICT
2889	PART-A COINSURANCE GREATER MEDICARE PD AMT
2890	REVIEW CROSSOVER PART B COINSURANCE OVER \$1000.00
2893	EXCEPTION CODE 893
2894	RURAL HEALTH REVENUE REQUIRES HCPC CODE
2895	RURAL HEALTH CLINIC REQUIRES REVENUE OP521
2896	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS
2900	PCS DAYS REDUCED-INPT/LTC CONFLICT
2901	FILE SEPARATE CLAIM FOR REMAINING UNPAID DAYS
2903	MULTIPLE CPT CODES REQUIRED
2904	DENIED FOR FLORIDA FOUNDATION FOR PEER REVIEW AUDIT
2905	REFILE SEPARATE CLAIM FOR EACH MONTH
2906	MEDICARE DEDUCTIBLE APPLIED IN PREVIOUS 60 DAYS
2907	PAY TO GROUP HAS BEEN PAID FOR THIS SERVICE
2908	ANOTHER PROVIDER WITHIN GROUP PAID FOR SERVICE
2909	FILE SEPARATE CLAIM FOR SEPTEMBER AND OCTOBER
2910	PSYCHIATRIC ADMIT AFTER 9/1/92 NEEDS PA
2911	SERVICE PREVIOUSLY PAID ON GROSS ADJUSTMENT
2912	CLAIM HAS BEEN ADJUSTED AFTER SPECIAL REVIEW
2913	CLAIM HAS BEEN ADJUSTED AFTER MEDICAL REVIEW
2914	SERVICE PREVIOUSLY PAID ON PROVIDER ALTERNATE NUM
2915	PAID TO ANOTHER PROVIDER IN GROUP ON ALTERNATE NUM
2916	EXCEPTION CODE 916
2917	CHARGES INDICATE ERROR IN MATH
2918	INDICATE UNITS WORKED NOT DAYS
2919	FILE SEPARATE CLAIM FOR EACH DATE OF SERVICE
2920	WAIVERED SERVICE/DATES NOT ON PRIOR AUTHORIZATION
2921	LIST EACH DATE SEPARATELY
2922	PATIENT RECEIVED SETTLE/BILL PATIENT
2923	ITEMIZE CHARGES FOR SUPPLIES
2924	CLIENT RESPONSIBLE EXCEEDS ALLOWABLE
2925	MEDICAL CONDITION/DIAGNOSIS NOT COVERED
2926	DME NAME BRAND DOES NOT MATCH ORDER NUMBER
2927	INDICATE EXACT UNITS PROVIDED FOR MEMBER
2928	WHOLESALE INVOICE REQUIRED FOR PAYMENT
2929	PROC/DIAG REQUIRE FEDERAL MANDATED STATMT-ABORTION
2930	PROCEDURE UNITS REDUCED TO ALLOWABLE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2931	EXCEPTION CODE 931
2932	DUPLICATE OF PREVIOUSLY PAID CROSSOVER CLAIM
2933	ORIGINAL CLAIM BEING ADJUSTED-ALLOW 30 DAYS
2934	CLAIM WAS FILED WITH INVALID PROVIDER NUMBER
2935	RENTAL PREVIOUSLY PAID FOR THIS ITEM THIS MONTH
2936	CONTACT CASE MANAGER OR SUPERVISOR
2937	PROVIDER NOT ELIGIBLE THIS PROCEDURE CODE
2938	EXCEPTION CODE 938
2939	REFILE ON PAPER CLAIM
2940	SUBMIT PAPER CLAIM WITH NARRATIVE FOR PRICING
2941	REFILE WITH MEDICARE REMITTANCE STATEMENT
2942	DUPLICATE PAID THRU FINANCE
2943	REFILE ON ADM84-TRANSPORTATION CLAIM FORM
2944	DENIED AFTER CLAIM CHECK REVIEW
2945	INVALID PROOF OF DENIAL/HMO
2946	INVALID PROOF OF INSURANCE DENIAL
2947	REFILE WITH CORRECT ADMIT DATE
2948	RESUBMIT LEGIBLE CLAIM/ATTACHMENT
2949	EXCEPTION CODE 949
2950	THIS LEVEL TRANSPORTATION NOT REQUIRED
2951	DDSD WILL PROCESS CLAIM THROUGH FINANCE
2952	REFILE-NAME BRAND AND PRODUCT/ORDER NUMBER FOR PRICE
2953	REFILE AS CROSSOVER WITH EOMP
2954	REFILE WITH APPROPRIATE EOMP
2955	NOT ELIGIBLE FOR WAIVERED SERVICES
2956	TPL PAID COLLECT FROM PATIENT
2957	NOT VERIFIED BY OPERATIVE REPORT
2958	ITEMIZE SURGERIES PER OPERATIVE REPORT
2959	CANNOT PROCESS NEGATIVE AMOUNTS
2960	ADJUSTED PER OFPR RECOMMENDATION
2961	NON EMERGENCY SERVICES NON PAYABLE FOR ALIEN
2962	DOCUMENT OF NECESSITY/MRI REPORT REQUIRED
2963	DOCUM DOES NOT JUSTIFY THE BILLED PROCEDURE
2964	REFILE CLAIM AS LIMIT TARGETED OB ULTRASOUND
2965	PAY REMAINING DAYS ON PARAMETER FILE
2966	FILE MEDICARE PART A FOR INPATIENT SERVICES
2967	PROVIDER NOT QUALIFIED FOR TARGETED OB US INTERP
2968	REFILE AS PHARMACY WITH NATIONAL DRUG CODE
2969	NO MEDICAL JUSTIFICATION FOR TARGETED OB US
2970	SUBMIT PREVIOUSLY REQUESTED OB/US QUALIFICATION
2971	PARTIAL HOURS NON ACCEPTABLE
2972	NO MEDICAL JUSTIFICATION FOR REVERSAL/REMOVAL
2973	REFILE AS AMBULATORY SURGERY
2974	PRESCRIBING PROVIDER EXCLUDED
2976	HYSTERECTOMY REQUIRE SIGN DATE
2977	REFILE CLAIM WITH MEDICAL RECORD
2978	INPATIENT HOSPITAL CLAIM PAID THIS DATE OF SERVICE
2979	NURSING HOME CLAIMS PAID THIS DATE OF SERVICE
2980	PROCEDURE NOT PAYABLE FOR THIS AGE
2981	VERIFY PA FOR THIS PROCEDURE/DATE OF SERVICE
2982	REFILE WITH PHYSICIAN PROGRESS NOTES
2983	PROV ID ON CLAIM DOES NOT MATCH PROV ID ON PA
2984	DIAGNOSIS NOT PAYABLE FOR NURSE MIDWIFE
2985	PROVIDER IS SUSPENDED OR TERMINATED
2986	UNITS CANNOT BE GREATER THAN 999

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
2987	PRIOR AUTHORIZATION UNITS/AMOUNTS USED
2988	TB ONLY ELIGIBLE - NEED T IN FORCE FIELD (FF)
2989	SERVICE AND/OR DATES DO NOT MATCH PRIOR AUTH
2990	SERVICES ALLOWED AS ENCOUNTER ON ALTERNATE NUMBER
2991	UNITS REDUCED PER DOCU/AFTER SURS REVIEW
2993	EXCEPTION CODE 993
2994	EXCEPTION CODE 994
2995	EXCEPTION CODE 995
2996	EXCEPTION CODE 996
2997	EXCEPTION CODE 997
2998	EXCEPTION CODE 998
2999	CLAIM BILLED WITH INACTIVE RID
3000	PRIOR AUTH LINE ITEM IS USED
3001	PA NOT ON FILE OR NOT IN DATE
3010	PRIOR AUTHORIZATION NUMBER IS MISSING
3023	FIRST SURGERY PROCEDURE IS ELECTIVE AND NO PRIOR AUTH NBR ENTERED. NON-PRIOR AUTHORIZED HYSTERECTOMIES PERMISSIBLE IN DOCUMENTED EMERGENCY SITUATIONS.
3024	ELECTIVE SURGERY: NO EMERGENCY REPORT
3034	EMERGENCY TREATMENT UNDER REVIEW-DENTAL
3035	PROCEDURE PERFORMED ON DOS AFTER PRIOR AUTHORIZATION EXPIRATION DATE
3036	ELECTIVE SURGERY EMERGENCY INDICATED
3037	ELECTIVE SURGERY - NO PRIOR AUTHORIZATION NUMBER ON CLAIM
3038	ELECTIVE SURGERY: NO SCREENING ON CLAIM
3039	OUT OF STATE CLAIM NOT PAYABLE, CLAIM REVIEWED. SERVICES NOT PRIOR AUTHORIZED AND NON EMERGENCY AND ARE THEREFORE NOT COVERED.
3041	PRIOR AUTH LINE NOT APPROVED
3042	RECIPIENT NUMBER ON PA DIFF VS CLAIM
3043	PRIOR AUTHORIZATION/PROCEDURE CODE MODIFIER CONFLICT
3044	PROVIDER NUMBER DOES NOT MATCH PRIOR AUTHORIZATION
3045	DENTAL CLAIM FILED BEFORE PRIOR AUTHORIZATION BEGINNING VALID DATE
3047	SERVICE DATE 912 DAYS AFTER PA ISSUE
3048	DIAGNOSIS IS 290.0-314.9 AND PA DOES NOT BEGIN 7777 FOR ADMIT PRIOR TO 7/1/98 OR 3333 FOR ADMIT ON OR AFTER 7/1/98, OR XXXX 895 XXX (AFTER 1/1/01)
3049	MEDICAL I/P PA NOT ON FILE OR DATE ON CLAIM IS NOT IN PA DATE SPAN
3050	PROCEDURE BILLED NOT IN PRIOR AUTHORIZATION RECORD
3051	DS WAIVER REFERRING PROVIDER INVALID
3052	PRIOR AUTHORIZATION FOR PROCEDURE CODE EXHAUSTED
3053	DS WAIVER NOT APPROVED
3054	UNIT RATE NOT ALLOWED
3055	DS WAIVER ERROR, DATA REJECTED BY GATEKEEPER MATRIX
3058	SCREENING REQUIRED, NONE INDICATED
3059	FIRST SURG PROC IS ELECTIVE. PROC REQUIRES PRIOR AUTH UNLESS PERFORMED AS A RESULT OF CHCUP SCREEN. SEE MEDICAID PRO REIM HANDBK P6-27
3322	INVALID UNITS OF SERVICE FOR REVENUE CODE 652, 652, 655-657 AND 659
3340	PROCEDURE CODE REQUIRES MANUAL PRICING
3348	DIAGNOSIS CODE NOT COVERED FOR BIRTH CENTER PROCEDURE CODE
3358	CLAIM REQUIRES AHCA MANUAL REVIEW
3360	TAXONOMY CODE INVALID/MISSING
3601	PROCEDURE/DIAGNOSIS/DRUG NOT COVERED FOR FAMILY PLANNING
3999	CLAIM BILLED WITH INACTIVE RID
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM
4003	DRUG IS LESS THAN EFFECTIVE - DESI
4008	INVALID RPICC SERVICE DAYS
4014	PROCEDURE BEING BILLED FOR PATHOLOGY HAS NO TECHNICAL COMPONENT SEGMENT
4016	PROCEDURE CODE INCOMPATIBLE WITH DIAG

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
4020	UNITS BILLED EXCEED ALLOWABLE UNITS FOR THIS PROCEDURE CODE
4026	NDC/DAYS SUPPLY LIMITATIONS. THIS NDC BILLED MAY NOT BE GREATER THAN THE NUMBER OF DAYS ALLOWED ON THE NDC FILE.
4030	DIAG CODE INCOMPATIBLE FOR RECIPIENTS AGE (IF YOU ARE BILLING FOR MOTHER, CHECK TO SEE IF YOU USED A NEWBORN-ONLY DIAG CODE OR VICE VERSA)
4033	INVALID PROCEDURE CODE MODIFIER COMBINATION
4034	PROCEDURE CODE/AGE CONFLICT
4035	PROCEDURE CODE OR DRUG / SEX CONFLICT
4036	PROVIDER TYPE/PLACE OF SERVICE CONFLICT
4037	DIAGNOSIS IS INCORRECT FOR PROCEDURE CODE BILLED
4039	DIAGNOSIS CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
4044	PROCEDURE CODE/AGE CONFLICT
4046	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE
4068	NO REIMB RULE FOR ASSOCIATED CONTRACT
4070	INVALID PROCEDURE CODE MODIFIER
4086	INDEPENDENT LAB NOT CERTIFIED
4089	MISSING OR INVALID SURGERY CODE. PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED WITH THE SURGERY REVENUE CODE AND RESUBMIT
4095	NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL
4098	PRICING BEING REVIEWED
4107	REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE (TYPE) OF SERVICE BEING PROVIDED
4108	PROVIDER CHARGE RECORD/ HMO PHP RECORD NOT FOUND
4114	PRICING BEING REVIEWED
4115	PRICING BEING REVIEWED
4119	VALUE CODE AMOUNT MISSING XYZ
4120	VALUE CODE IS MISSING
4121	MOUTH QUADRANT REQUIRED
4122	VALUE CODE IS INVALID
4123	VALUE CODE AMOUNT IS MISSING
4124	VALUE CODE AMOUNT IS INVALID
4127	CANNOT PRIORITIZE MEMBERS PROGRAMS
4134	DRG GRPR NOT ABLE TO GROUP WITH INFO PROVIDED
4140	PAY-TO PROVIDER TYPE INVALID FOR PROCEDURE CODE
4142	REVENUE CODE NOT ALLOWED FOR DIALYSIS PROVIDER
4149	PROCEDURE RESTRICTED TO CERTAIN SPECIALTY(IES). PROVIDER NOT ENROLLED FOR NECESSARY SPECIALTY. (OR TREATING PROV NOT IDENTIFIED ON CLAIM).
4150	PROCEDURE/PROVIDER CONFLICT
4161	INDEPENDENT LAB NOT CERTIFIED
4162	INVALID HOSPICE REVENUE CODE OR INVALID COMBINATION OF HOSPICE REVENUE CODES
4181	ENCOUNTER BLANKET DENIAL
4183	INVALID COMBINATION OF RPICC SERVICES. THERE IS TPL FOR THIS CLAIM
4201	NO RATE ON PROCEDURE FILE FOR DATE OF SERVICE
4203	THIS SERVICE IS A NON-COVERED FLORIDA HEALTH COVERAGE PROGRAM SERVICE AS THE RENDERING PROVIDER IS NOT RECOGNIZED BY THE FLORIDA HEALTH COVERAGE PROGRAM
4206	INVALID RPICC SERVICE DAYS
4208	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER
4209	NO MATCHING PRICING SEGMENT FOR THE PROCEDURE/MODIFIER COMBINATION BILLED
4215	REVENUE CODE NOT VALID FOR THIS BILL TYPE
4216	MODIFIERS 24, 78 AND 79 REQUIRE AHCA REVIEW
4218	INVALID PROCEDURE FOR CLAIM FORM
4220	EPOGEN REQUIRES VALUE CODE 68
4223	PROCEDURE REQUIRES MEDICAL REVIEW
4227	THIS REVENUE CODE IS NOT COVERED FOR THIS MEMBER
4229	DIAGNOSIS REQUIRES MEDICAL REVIEW
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE
4252	DIAGNOSIS CODE 10-24 NOT ON FILE
4253	REVENUE CODE REQUIRES MEDICAL REVIEW
4254	REVENUE CODE VS AGE RESTRICTION
4257	INVALID PROCEDURE CODE MODIFIER
4282	CLAIM HAS BEEN REVIEWED. REFER TO EOB CODES 1901 - 1940 FOR DENIAL REASON.
4311	DIAG CODE MISSING OR INCOMPLETE. OUTPATIENT HOSP - REV CODES 273 AND 279 NOT PAYABLE UNLESS DIAGNOSIS IS INCLUDED IN RANGE 940.0-949.5.
4312	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE
4315	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE
4316	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE
4350	DIAGNOSIS REQUIRES MEDICAL REVIEW
4351	ICD9 PROCEDURE REQUIRES MEDICAL REVIEW
4352	DIAGNOSIS REQUIRES AHCA MEDICAL REVIEW
4353	ICD9 PROCEDURE REQUIRES AHCA MEDICAL REVIEW
4371	PROCEDURE CODE NOT COVERED FOR CLAIM TYPE
4384	GROUPEL ERROR - PRIMARY DIAGNOSIS INVALID
4388	DRG GROUPEL INVALID AGE
4389	DRG GROUPEL INVALID GENDER
4390	DRG GROUPEL INVALID DISCHARGE STATUS
4391	DRG GROUPEL INVALID LENGTH OF STAY
4393	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION
4415	PROCEDURE NOT ALLOWED WITH NOT ALLOWED WITH S5102
4486	RECIPIENT ID NOT ON FILE. DENIED AFTER PENDING 14 DAYS AWAITING AHCA UPDATE IF NUMBER IS INCORRECT, RESUB. IF CORRECT, CONTACT YOUR AHCA DISTRICT OFFICE.
4711	DIAGNOSIS CODE INCOMPATIBLE FOR RECIPIENTS AGE. IF YOU ARE BILLING FOR MOTHER, CHECK TO SEE IF YOU USED A NEWBORN-ONLY DIAG CODE OR VICE VERSA.
4714	PROCEDURE CODE/AGE CONFLICT
4715	PROCEDURE CODE/AGE CONFLICT
4742	DIAG CODE MISSING OR INCOMPLETE. OUTPATIENT HOSP - REV CODES 273 AND 279 NOT PAYABLE UNLESS DIAGNOSIS IS INCLUDED IN RANGE 940.0-949.5.
4760	ICD9 PROCEDURE REQUIRES MEDICAL REVIEW
4768	ICD9 PROCEDURE REQUIRES MEDICAL REVIEW
4776	DIAGNOSIS NOT COVERED
4798	SUBMITTED CHARGE IS NOT EVENLY DIVISIBLE BY UNITS OF SERVICE
4801	THESE SERVICES CANNOT BE BILLED ON THIS CLAIM FORM OR THE PROVIDER TYPE LISTED FOR THIS PROVIDER NUMBER CANNOT FILE THIS TYPE OF CLAIM
4802	NO CONTRACT FOR BILLED DIAGNOSIS
4804	PROVIDER INELIGIBLE FOR CATEGORY OF SERVICE FOR THIS DATE OF SERVICE
4806	PROVIDER INELIGIBLE FOR CATEGORY OF SERVICE FOR THIS DATE OF SERVICE
4812	DIAGNOSIS REQUIRES MEDICAL REVIEW
4813	PROCEDURE REQUIRES MEDICAL REVIEW
4821	PROV TYPE/PLACE OF SERVICE CONFLICT
4822	PROC CAN NOT BE PERFORMED AT PLACE OF SERVICE INDICATED ON CLAIM OR IF 99160 OR 99162 BILLED. SERV PAYABLE ONLY IF EMERGENCY BLOCK CHECKED.
4871	PROCEDURE CODE NOT COVERED FOR CLAIM TYPE
4874	OUTPATIENT REV CODE NOT ON FILE OR NOT COVERED - IF REV CODE IS IN THE RANGE 960-981 (PROFESSIONAL SERVICES), IT MUST BE BILLED ON THE CMS-1500
4888	NDC MISSING/INVALID
4889	INVALID NDC/J-CODE COMBINATION
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM
5001	THIS IS A DUPLICATE OF ANOTHER CLAIM
5002	THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT
5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
5004	REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEASE REFER TO YOUR POS MANUAL.
5005	REVERSAL NOT PROCESSED - MULTIPLE MATCHES FOUND WITH SAME RX NUMBER, PROVIDER NUMBER AND DISPENSING DATE. PLEASE REFER TO YOUR POS MANUAL.
5006	REVERSAL NOT PROCESSED, CLAIM OVER 60 DAYS - SUBMIT MANUAL ADJUSTMENT
5007	THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJUSTMENT, PLEASE SUBMIT THE APPROPRIATE ADJUSTMENT REQUEST FORM.
5010	EXACT DUPLICATE - TOOTH SURFACE
5017	MOUTH QUADRANT/ TOOTH SURFACE DUPLICATE
5030	NOT ALLOWED SAME DATE OF SERVICE
5031	PROCEDURE NOT ALLOWED SAME DATE OF SERVICE
5032	NOT ALLOWED WITH COMPONENT
5033	NOT ALLOWED SAME DAY WITH CMH SERVICES
5034	NOT ALLOWED ON SAME DATE OF SERVICE FOR CMH.
5035	PAID RELATED CLAIM
5036	NOT ALLOWED WITH C-SECTION
5038	INVALID PROCEDURE/MODIFIER COMBINATION
5042	NOT ALLOWED WITH OBSTETRIC PANEL
5043	NOT ALLOWED WITH OBSTETRIC PANEL-LABORATORY
5045	NOT ALLOWED WITH HEPATIC FUNCTION
5046	NOT ALLOWED WITH HEPATITIS FUNCTION
5048	NOT ALLOWED WITH LIPID PANEL
5049	NOT ALLOWED WITH LIPID PANEL - LABORATORY
5051	NOT ALLOWED WITH ARTHRITIS PANEL - LABORATORY
5052	NOT ALLOWED WITH ARTHRITIS PANEL ? TORCH ANTIBODY PANEL
5053	NOT ALLOWED WITH ARTHRITIS PANEL ? TORCH ANTIBODY PANEL LAB
5056	SERVICES NOT ALLOWED ON THE SAME DAY
5057	SERVICE NOT ALLOWED WITH ANESTHESIA
5058	PROCEDURE CODE COMBINATION NOT ALLOWED
5059	MULTIPLE VISITS SAME DAY
5060	PROCEDURE CODE COMBINATION NOT ALLOWED
5061	PROCEDURE CODE COMBINATION NOT ALLOWED
5062	PROCEDURE CODE COMBINATION NOT ALLOWED
5063	PROCEDURE CODE COMBINATION NOT ALLOWED
5065	PROCEDURE CODE COMBINATION NOT ALLOWED
5066	PROCEDURE CODE COMBINATION NOT ALLOWED
5067	PROCEDURE CODE COMBINATION NOT ALLOWED
5068	PROCEDURE CODE COMBINATION NOT ALLOWED
5069	PROCEDURE CODE COMBINATION NOT ALLOWED
5070	PROCEDURE CODE COMBINATION NOT ALLOWED
5071	PROCEDURE CODE COMBINATION NOT ALLOWED
5072	PROCEDURE CODE COMBINATION NOT ALLOWED
5073	PROCEDURE CODE COMBINATION NOT ALLOWED
5074	PROCEDURE CODE COMBINATION NOT ALLOWED
5075	PROCEDURE CODE COMBINATION NOT ALLOWED
5076	PROCEDURE CODE COMBINATION NOT ALLOWED
5077	PROCEDURE CODE COMBINATION NOT ALLOWED
5078	PROCEDURE CODE COMBINATION NOT ALLOWED
5079	PROCEDURE CODE COMBINATION NOT ALLOWED
5080	PROCEDURE CODE COMBINATION NOT ALLOWED
5081	PROCEDURE CODE COMBINATION NOT ALLOWED
5082	PROCEDURE CODE COMBINATION NOT ALLOWED
5083	PROCEDURE CODE COMBINATION NOT ALLOWED
5084	PROCEDURE CODE COMBINATION NOT ALLOWED
5085	PROCEDURE CODE COMBINATION NOT ALLOWED

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
5086	PROCEDURE CODE COMBINATION NOT ALLOWED
5087	PROCEDURE CODE COMBINATION NOT ALLOWED
5088	PROCEDURE CODE COMBINATION NOT ALLOWED
5089	PROCEDURE CODE COMBINATION NOT ALLOWED
5090	PROCEDURE CODE COMBINATION NOT ALLOWED
5091	PROCEDURE CODE COMBINATION NOT ALLOWED
5092	PROCEDURE CODE COMBINATION NOT ALLOWED
5093	PROCEDURE CODE COMBINATION NOT ALLOWED
5094	PROCEDURE CODE COMBINATION NOT ALLOWED
5095	PROCEDURE CODE COMBINATION NOT ALLOWED
5096	PROCEDURE CODE COMBINATION NOT ALLOWED
5097	PROCEDURE CODE COMBINATION NOT ALLOWED
5098	PROCEDURE CODE COMBINATION NOT ALLOWED
5099	PROCEDURE CODE COMBINATION NOT ALLOWED
5100	PROCEDURE CODE COMBINATION NOT ALLOWED
5101	PROCEDURE CODE COMBINATION NOT ALLOWED
5102	PROCEDURE CODE COMBINATION NOT ALLOWED
5104	SERVICES NOT ALLOWED ON THE SAME DAY
5111	SERVICES NOT ALLOWED ON THE SAME DAY (STANDBY)
5112	SERVICES NOT ALLOWED ON THE SAME DAY (NEWBORN)
5113	SERVICES NOT ALLOWED ON THE SAME DAY (EPSDT)
5114	BED RAILS PURCHASED WITH BED
5115	NOT ALLOWED SAME DAY, SAME RECIPIENT, SAME PROVIDER
5116	NOT ALLOWED WITH EP STUDIES
5117	SERVICE NOT ALLOWED WITH NICU (VARIED)
5118	NOT ALLOWED WITH COMPONENT
5119	NOT ALLOWED WITH COMPONENT
5120	SPEECH THERAPIES NOT ALLOWED SAME DAY
5121	CMH SERVICES NOT ALLOWED SAME DAY
5122	NOT ALLOWED SAME DAY WITH CMH SERVICES
5123	NOT ALLOWED SAME DAY WITH CMH SERVICES
5124	NOT ALLOWED WITH C-SECTION
5125	NOT ALLOWED WITH 85018
5126	NOT ALLOWED WITH 87220
5127	NOT ALLOWED WITH PINWORM EXAM
5128	SERVICE NOT ALLOWED WITH CRITICAL CARE
5129	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (VARIED)
5130	SERVICE NOT ALLOWED WITH NICU
5132	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (MEDICINE, PSYCH)
5133	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (EMERGENCY SCREENING)
5134	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (CPAP)
5135	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (HOSPITAL CARE/FOLLOW-UP)
5136	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (CIRCUMCISION)
5137	NOT ALLOWED SAME DATE OF SERVICE - OB
5138	NOT ALLOWED SAME DATE OF SERVICE ? HOME HEALTH
5139	NOT ALLOWED WITH ER SCREENING
5140	NOT ALLOWED WITH STFC CRISIS (S5145 HK)
5142	NOT ALLOWED WITH ROOT CANALS
5143	NOT ALLOWED WITH PULP DEBRIDE
5144	NOT ALLOWED WITH OFFICE REPAIR (W3056)
5145	NOT ALLOWED WITH DISPENSING (V0235)
5146	NOT ALLOWED SAME DAY SAME RECIPIENT SAME PROVIDER (LABOR MANAGEMENT)
5147	NOT ALLOWED SAME DAY SAME RECIPIENT SAME PROVIDER (LABOR MANAGEMENT)
5148	NOT ALLOWED SAME DAY SAME RECIPIENT SAME PROVIDER (LABOR MANAGEMENT)
5149	PPEC SERVICES NOT ALLOWED SAME DAY

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
5150	SERVICES NOT ALLOWED ON THE SAME DAY
5151	SERVICES NOT ALLOWED ON THE SAME DAY (90749)
5152	PROCEDURE NOT ALLOWED SAME DATE OF SERVICE - PHARMACOLOGICAL MANAGEMENT
5415	PROCEDURE NOT ALLOWED WITH NOT ALLOWED WITH S5101
5473	PROCEDURE CODE COMBINATION NOT ALLOWED
5474	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
5475	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
5476	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
5477	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
5500	STEP THERAPY REQUIREMENTS NOT MET FOR THIS DRUG
5501	INPATIENT CLAIM DUPLICATE OF OUTPATIENT CLAIM OR VICE VERSA. OUTPATIENT SERV NOT PAYABLE FOR DAY BEFORE OR SAME DAY OF AN INPATIENT ADMISSION.
5512	RURAL HEALTH ENCOUNTER LIMIT. CANNOT BILL MULTIPLE RURAL HEALTH ENCOUNTERS FOR THE SAME SERVICE DATE.
5514	FOHC ENCOUNTER LIMIT - CANNOT BILL MULTIPLE FOHC ENCOUNTERS FOR THE SAME SERVICE DATE.
5578	FIRST DATE OF SERVICE IS BEFORE THE RECIPIENTS DATE OF BIRTH. TAPE OR ASAP BILLING - DENY
5626	INVALID COMBINATION OF RPICC SERVICES. THERE IS TPL FOR THIS CLAIM
5627	INVALID COMBINATION OF RPICC SERVICES. THERE IS TPL FOR THIS CLAIM.
5831	PROCEDURE CANNOT BE BILLED INDEPENDENTLY
5924	THIS PROC IS CONSIDERED CONTENT OF SERVICE OF ANOTHER PROC BILLED ON THE SAME CLAIM
5925	THIS PROC IS CONTENT OF SERV OF A LESSER PROC BILLED ON A SEPARATE CLAIM OR PAID IN HISTORY
5926	THIS PROC IS CONTENT OF SERV OF A GREATER PROC BILLED ON A CLAIM OR PAID IN HISTORY
5935	COMPONENT LAB PROCEDURES SHOULD BE BILLED USING THE LAB PANEL CODE
6030	PROCEDURE IS LIMITED TO ONE TIME IN A ONE YEAR PERIOD. IF YOU BILLED FOR MORE THAN ONE UNIT ON THIS CLAIM, REBILL FOR ONE UNIT ONLY.
6031	PROCEDURE IS LIMITED TO ONE TIME IN A ONE YEAR PERIOD. IF YOU BILLED FOR MORE THAN ONE UNIT ON THIS CLAIM, REBILL FOR ONE UNIT ONLY.
6032	PROCEDURE IS LIMITED TO THREE TIMES IN ONE YEAR PERIOD PER RECIPIENT
6033	PROCEDURE LIMITED TO TWO TIMES IN A ONE YEAR PERIOD
6034	PROCEDURE LIMITED TO TWO TIMES IN A ONE YEAR PERIOD
6035	THIS PROCEDURE IS LIMITED TO FOUR TIMES IN A LIFETIME. RESUBMIT CLAIM AND ATTACH DOCUMENTATION WHICH JUSTIFIES EXCEEDING THE LIMIT.
6037	LIMIT FIVE TIMES PER LIFETIME
6038	DENTURE RELININGS ARE LIMITED TO ONE PER DENTURE IN ONE YEAR. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6039	PROCEDURES APPLICABLE TO THIS EXCEPTION ARE LIMITED TO THREE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6040	SERVICE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN EXCEEDED
6041	PAID RELATED CLAIM
6042	MALOCCLUSION ADJUSTMENT LIMIT 24 PER LIFETIME
6043	INITIAL CONSULTATIONS ARE LIMITED TO ONE PER RECIPIENT PER PROVIDER
6044	CRUTCHES ARE LIMITED TO ONE PER YEAR
6046	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS PER CLIENT PER MONTH
6047	PROCEDURE LIMITED TO 4 TIMES PER MONTH PER RECIPIENT WHEN PERFORMED IN A NURSING HOME. SERVICE LIMIT EXCEEDED.
6052	VISIT LIMITATION EXCEEDED
6054	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
6055	HEARING AID DISPENSING FEES ARE LIMITED TO ONE IN THREE YEARS
6059	UNITS OF SERVICE EXCEED ALLOWED FOR THIS REVENUE CODE
6060	UNITS OF SERVICE EXCEED ALLOWED FOR THIS REVENUE CODE
6061	W1074 LIMITED TO 26 PER FISCAL YEAR FOR CMH
6062	MORE THAN TWO SURGEONS BILLED MODIFIER 62 FOR SAME RECIPIENT, DOS, PROCEDURE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6063	CMH LIMIT TO ONE PER FISCAL YEAR
6064	BILLABLE LIMIT ONCE MONTHLY
6065	COMPREHENSIVE ASSESSMENT LIMITED TO ONE PER FISCAL YEAR
6066	PROCEDURE LIMITED TO ONE TIME IN SIX MONTHS
6067	NEBULIZER RENTAL LIMIT EXCEEDED.
6068	TREATMENT PLAN REVIEW LIMITED TO SIX TIMES PER FISCAL YEARS
6069	PROCEDURE IS LIMITED TO TWO TIMES IN THREE YEARS. IF YOU BILLED FOR MORE THAN TWO UNITS ON THIS CLAIM, REBILL FOR TWO UNITS ONLY.
6071	PROCEDURE LIMITED TO FOUR TIMES IN A LIFETIME
6072	ONE NEW HOME VISIT PER LIFE TIME PER PROVIDER PER RECIPIENT. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6073	NEW PATIENT NURSING HOME VISITS ARE LIMITED TO ONE PER LIFETIME PER RECIPIENT
6074	PROCEDURE IS LIMITED TO TWO TIMES IN THREE YEARS. IF YOU BILLED FOR MORE THAN TWO UNITS ON THIS CLAIM, REBILL FOR TWO UNITS ONLY.
6075	SERVICE LIMITED TO ONE/THREE YEARS
6076	C-SECTIONS OR TOTAL OB CARE IS LIMITED TO ONE IN 300 DAYS
6079	PROCEDURE LIMITED TO FOUR TIMES IN A LIFETIME
6080	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT.
6081	THIS PROCEDURE IS LIMITED TO TWO IN 280 DAYS
6082	NEPHRECTOMY IS LIMITED TO TWO IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6083	ORCHIECTOMY IS LIMITED TO TWO IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6084	SALPINGECTOMY/OOPHORECTOMY IS LIMITED TO TWO IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6085	APPENDECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6086	NEW PATIENT VISIT HAS BEEN PREVIOUSLY PAID
6087	VISIT LIMITATION EXCEEDED
6089	THIS PROCEDURE LIMITED TO 6 UNITS PER YEAR PER CLIENT
6090	MASTOIDECTOMY IS LIMITED TO TWO IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6091	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6092	LARYNGECTOMY IS LIMITED TO ONE PER LIFETIME
6093	PATIENT DUCTUS ARTERIOSUS IS LIMITED TO ONE TIME PER LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6095	SPLENECTOMY IS LIMITED TO ONE TIME IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6096	LIMIT OF ONE PRENATAL PAYMENT A YEAR
6097	COMPLETE GASTRECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6098	ONE PER MONTH
6099	ASSISTIVE CARE PROVIDERS CANNOT BILL FOR MORE THAN 31 UNITS PER MONTH. PLEASE CHECK THE SUBMITTED CLAIM FOR THE CORRECT UNITS.
6100	HEPATECTOMY IS LIMITED TO ONE TIME IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6101	CHOLECYSTECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6102	CYSTECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6103	NORMAL NEWBORN CARE. LIMIT 1 IN LIFETIME.
6104	TOTAL HYSTERECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6105	C SECTION WITH HYSTERECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6106	VAGINAL DELIVERIES OR TOTAL OB CARE IS LIMITED TO ONE PER RECIPIENT IN 280 DAYS. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6107	SERVICES APPLICABLE TO THIS EDIT ARE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6108	WHEEL CHAIR RENTAL LIMITED TO 10 PAYMENTS IN TEN MONTHS, ONCE PER LIFETIME
6109	PROCEDURES APPLICABLE TO THIS EDIT ARE LIMITED TO ONE IN THREE YEARS
6110	WALKERS ARE LIMITED TO ONE PER YEAR
6111	PROCEDURE APPLICABLE TO THIS EDIT ARE LIMITED TO 10 IN A LIFETIME

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6112	RENTAL OF HOSPITAL BED SIDE RAILS IS LIMITED TO 10 IN A RECIPIENT'S LIFETIME
6113	THIS PROCEDURE IS LIMITED TO FOUR IN ONE WEEK. LIMIT HAS BEEN MET
6114	DESCRIPTION FOR THIS EOB IS NOT IN THE EOB DESCRIPTIONS ADJ RSN CD REMRK CD TEXT FILE. FOLLOW UP REQUIRED.
6115	THIS PROCEDURE IS LIMITED TO TWO TIMES IN A LIFETIME
6116	LIMITED TO 52 PER FISCAL YEAR CMH
6118	2PROCEDURE LIMITED TO ONE TIME IN A ONE YEAR PERIOD
6119	99203/99214 LIMITED TO ONE PER FISCAL YEAR FOR CMH
6122	THIS PROCEDURE IS LIMITED TO ONE TIME IN A LIFETIME
6123	THIS PROCEDURE IS LIMITED TO TWO TIMES IN A LIFETIME
6125	SERVICE LIMIT 224 UNITS IN 7 DAYS PER RECIPIENT
6126	THIS PROCEDURE IS LIMITED TO 10 IN 280 DAYS
6127	THIS PROCEDURE IS LIMITED TO 14 IN 280 DAYS
6128	ONE VISIT PER RECIPIENT PER PROVIDER PER MONTH
6131	CHIROPRACTIC SERVICES ARE LIMITED TO TWENTY-FOUR PER CALENDAR YEAR
6132	PROCEDURE IS LIMITED TO TWO TIMES IN THREE YEARS. IF YOU BILLED FOR MORE THAN TWO UNITS ON THIS CLAIM, REBILL FOR TWO UNITS ONLY.
6133	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6134	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6135	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6136	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6137	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6138	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6139	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6140	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6141	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6142	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6143	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6144	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6145	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6146	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6147	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6148	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6149	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6150	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6151	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6152	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6153	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6154	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6155	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6156	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
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6159	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6160	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6161	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6162	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6163	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6164	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6166	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6167	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6168	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6169	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6170	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6171	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6172	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6173	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6174	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6175	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6176	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6177	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6178	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6179	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6180	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6181	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6182	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6183	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6184	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6185	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6186	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6187	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6188	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6189	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6190	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6191	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6192	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6193	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6194	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6195	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6196	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6197	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6198	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
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6201	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6202	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6203	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6204	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6205	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6206	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6207	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6208	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6209	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6210	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6211	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6212	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6213	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6214	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6215	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6216	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6217	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6218	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6219	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6220	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6221	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6222	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6223	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6224	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6225	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6226	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6227	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6228	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6229	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6230	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6231	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6232	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6233	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6234	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6235	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6236	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6237	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6238	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6239	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6240	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6241	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6242	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6243	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6244	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6245	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6246	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6247	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6248	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6249	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6250	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6251	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6252	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6253	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6254	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6255	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6256	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6257	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6258	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6259	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6260	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6261	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6262	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6263	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6264	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6265	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6266	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6267	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6268	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6269	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6270	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6271	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6272	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6273	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6274	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6275	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6276	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6277	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6278	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6279	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6280	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6281	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6282	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6283	UNIT/VISIT LIMIT EXCEEDED
6284	UNIT/VISIT LIMIT EXCEEDED
6285	UNIT/VISIT LIMIT EXCEEDED
6286	UNIT/VISIT LIMIT EXCEEDED
6287	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6288	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6289	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6290	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6291	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6292	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6293	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6294	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6295	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6296	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6297	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6298	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6299	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6300	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6301	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6302	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6303	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6304	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6305	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6306	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6307	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6308	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6309	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6310	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6311	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6312	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6313	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6314	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6315	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6316	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6317	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6318	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6319	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6320	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6321	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6322	THIS PROCEDURE LIMITED TO ONCE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
6323	CHIROPRACTIC SERVICES ARE LIMITED TO TWELVE IN TWELVE MONTHS
6324	THIS PROCEDURE LIMITED TO \$500.00 PER MONTH PER CLIENT
6325	THIS PROCEDURE LIMITED TO \$500.00 PER MONTH PER CLIENT
6326	SERVICE NOT AUTHORIZED BY MEDIPASS PRIMARY CARE PHYSICIAN. REFERRING PHYSICIAN NOT MEDIPASS PRIMARY CARE PHYSICIAN.
6328	CONSENT FORM INCOMPLETE. YOU MAY COMPLETE ANY ITEM ON THE FORM EXCEPT SIGNATURE AND DATE OF: PATIENT, PERSON OBTAINING CONSENT AND INTERPRETER.
6329	CONSENT FORM INCOMPLETE. YOU MAY COMPLETE ANY ITEM ON THE FORM EXCEPT SIGNATURE AND DATE OF: PATIENT, PERSON OBTAINING CONSENT AND INTERPRETER.
6330	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
6331	SERVICE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN EXCEEDED
6332	ASSISTIVE CARE PROVIDERS CANNOT BILL FOR MORE THAN 31 UNITS PER MONTH. PLEASE CHECK THE SUBMITTED CLAIM FOR THE CORRECT UNITS.
6333	THIS PROCEDURE IS LIMITED TO ONE IN SEVEN DAYS

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6334	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6335	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6336	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6337	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6338	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6339	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6340	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6341	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6342	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6343	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6344	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6345	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6346	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6347	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6348	HMO REFORM SERVICE LIMIT OF 280 DAYS FOR OB SERVICES
6349	HOSPITAL BEDS LIMITED TO 10 RENTAL PAYMENTS IN A RECIPIENTS LIFETIME
6350	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
6351	TREATMENT PLAN REVIEW LIMITED TO SIX TIMES PER FISCAL YEARS
6352	LENS TINTS ARE LIMITED TO TWO IN TWO YEARS
6353	CANES ARE LIMITED TO ONE PER YEAR
6354	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6355	PROCEDURE MODIFIER BILLED REQUIRES MANUAL PRICING. PLEASE RESUBMIT WITH MEDICAL REPORT ATTACHED.
6356	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6357	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6358	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6359	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6360	SNU MAX DAYS EXCEEDED
6361	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6362	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6363	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6364	HOSPICE CAP LIMIT REACHED
6365	PROCEDURE LIMITED TO TWO TIMES IN A ONE YEAR PERIOD
6368	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6369	CLAIM/DETAIL DENIED. T1028 UA LIMITED TO 2 UNITS PER 366 DAYS.
6370	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 UNIT PER MONTH.
6371	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$7500 PER 366 DAYS.
6372	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$10,000 PER 366 DAYS.
6373	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$300 PER 366 DAYS.
6374	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$5000 PER 366 DAYS.
6375	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 14 UNITS PER MONTH.
6376	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 1 UNIT PER 8 YEARS.
6377	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 PER MONTH.
6378	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 UNIT PER 8 YEARS.
6379	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 52 PER 365 DAYS.
6380	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 PER MONTH.
6514	HOME HEALTH LIMITS EXCEEDED FOR 1 MONTH
6554	WAIVER LIMIT FOR PHARMACY HAS BEEN REACHED
6658	DUPLICATE DENTAL RESIN WITHIN THREE YEARS
6660	THERAPEUTIC LEAVE DAYS GREATER THAN 14 CANNOT BE BILLED
6661	PROFESSIONAL AND TECHNICAL COMPONENTS OF SERVICES ARE NOT PAYABLE WHEN THE COMPREHENSIVE SERVICE HAS BEEN PAID
6700	FOLLOW-UP VISITS NOT PAYABLE WITHIN 10 DAYS OF SURGICAL PROCEDURE
6701	FOLLOW-UP VISITS NOT PAYABLE WITHIN 30 DAYS OF SURGICAL PROCEDURE
6702	FOLLOW-UP VISITS NOT PAYABLE WITHIN 45 DAYS OF SURGICAL PROCEDURE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
6703	FOLLOW-UP VISITS NOT PAYABLE WITHIN 60 DAYS OF SURGICAL PROCEDURE
6704	FOLLOW-UP VISITS NOT PAYABLE WITHIN 90 DAYS OF SURGICAL PROCEDURE
6734	SERVICE NOT AUTHORIZED BY MEDIPASS PRIMARY CARE PHYSICIAN. REFERRING PHYSICIAN NOT MEDIPASS PRIMARY CARE PHYSICIAN.
6735	SERVICE NOT AUTHORIZED BY MEDIPASS PRIMARY CARE PHYSICIAN. REFERRING PHYSICIAN NOT MEDIPASS PRIMARY CARE PHYSICIAN.
6861	PROCEDURE INVALID IN NURSING HOME
6863	POSSIBLE DUPLICATE CONFLICT. MAY BE A CONFLICT WITH ANOTHER PROVIDERS CLAIM
7000	CLAIM FAILED A PRODUR ALERT
7001	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT
7010	TOTAL UNITS GREATER THAN TOT DAYS
7200	MISCELLANEOUS CLAIMCHECK ERROR
7201	PROCEDURE IS A NEWBORN PROCEDURE; AGE SHOULD BE LESS THAN 1 YEAR
7202	PROCEDURE IS A PEDIATRIC PROCEDURE; AGE SHOULD BE 1-17 YEARS
7203	PROCEDURE IS A MATERNITY PROCEDURE; AGE SHOULD BE 12-55 YEARS
7204	PROCEDURE IS AN ADULT PROCEDURE; AGE SHOULD BE OVER 14 YEARS
7205	PROCEDURE IS NOT INDICATED FOR A MALE
7206	PROCEDURE IS NOT INDICATED FOR A FEMALE
7207	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE
7208	PROCEDURE IS AN UNLISTED PROCEDURE
7209	PROCEDURE IS CLASSIFIED AS EXPERIMENTAL
7210	PROCEDURE IS CLASSIFIED AS OBSOLETE
7211	PROCEDURE IS INVALID FOR PATIENTS AGE
7212	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (AGE)
7213	PROCEDURE IS INVALID FOR PATIENTS SEX
7214	PROCEDURE ADDED DUE TO ALTERNATE CODE REPLACEMENT (SEX)
7215	PROCEDURE CODE IS INCIDENTAL
7216	VISIT PROCEDURE CODE IS NOT INDICATED FOR SEPARATE REIMBURSEMENT
7217	PROCEDURE CODE HAS BEEN REBUNDLED
7218	PROCEDURE ADDED DUE TO REBUNDLING
7219	PROCEDURE IS MUTUALLY EXCLUSIVE
7220	PROCEDURE IS WITHIN THE NUMBER OF DAYS PRE-OP RANGE
7221	PROCEDURE IS WITHIN THE NUMBER OF DAYS POST-OP RANGE
7222	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON
7223	PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON
7233	DUPLICATE DENIED - INCLUDES UNILATERAL OR BILATERAL
7234	DENIED DUPLICATE - IS BILATERAL
7235	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN LIFETIME
7236	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY
7237	DENIED DUPLICATE (REBUNDLED)
7238	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING
7239	PROCEDURE IS A POSSIBLE DUPLICATE
7240	SMARTSUSPENSE SUSPEND
7241	SMARTSUSPENSE DENIAL
7242	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE DENIED
7243	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE SUSPENDED
7244	MEDICAL VISIT DENIED
7245	PROCEDURE ADDED DUE TO NEW VISIT FREQUENCY CODE REPLACEMENT
7246	PROCEDURE REPLACED DUE TO INTENSITY OF SERVICE REPLACEMENT
7247	PROCEDURE ADDED DUE TO INTENSITY OF SERVICE REPLACEMENT
7248	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7249	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7250	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7251	PROCEDURE IS ELIGIBLE FOR WORKERS COMPENSATION/AUTO PAYOR
7252	DIAGNOSIS 1 HAS BEEN DETECTED AS BEING ELIGIBLE FOR 3RD PARTY PAYOR BY CLAIMC

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
7253	DIAGNOSIS 2 HAS BEEN DETECTED AS BEING ELIGIBLE FOR 3RD PARTY PAYOR BY CLAIMC
7254	DIAGNOSIS 3 HAS BEEN DETECTED AS BEING ELIGIBLE FOR 3RD PARTY PAYOR BY CLAIMC
7255	DIAGNOSIS 4 HAS BEEN DETECTED AS BEING ELIGIBLE FOR 3RD PARTY PAYOR BY CLAIMC
7256	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE
7257	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE
7258	REVIEW MODIFIER 51
7259	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS
7260	MORE THAN 40 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSING
7261	INVALID CHCUP REFERRAL CODE
7262	DOB CANNOT BE GREATER THAN DATE OF SERVICE
7263	DOS REQUIRED FOR PROCEDURE
7264	DOS CANNOT BE A FUTURE DATE
7265	BIRTHDATE CANNOT BE A FUTURE DATE
7266	AGE CANNOT BE GREATER THAN 124 YEARS
7267	ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES
7268	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES
7269	MODIFIER NOT VALID FOR THIS PROCEDURE
7270	INVALID MODIFIER/PROCEDURE CODE COMBINATION
7271	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID
7272	DIAGNOSIS 1 MUST BE A VALID CODE
7273	DIAGNOSIS 2 MUST BE A VALID CODE
7274	DIAGNOSIS 3 MUST BE A VALID CODE
7275	DIAGNOSIS 4 MUST BE A VALID CODE
7276	DIAGNOSIS MUST BE A VALID CODE
7277	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE
7278	INVALID DATE (DATE OF BIRTH)
7279	INVALID AMOUNT CHARGED
7280	CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER IS REQUIRED
7281	DIAGNOSIS TO PROCEDURE COMPARISON PROCEDURE
7282	INTENSITY OF PROCEDURE WAS FOUND TO BE HIGHER THAN EXPECTED BASED ON DIAGNOSIS
7283	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE MULTIPLE COMPONENT
7284	PROCEDURE SHOULD BE REVIEWED AS POSSIBLE DUPLICATE COMPONENT
7285	PROCEDURE IS ELIGIBLE FOR WORKERS COMPENSATION/AUTO PAYOR
7286	DIAGNOSIS IS ELIGIBLE FOR WORKERS COMPENSATION/AUTO PAYOR
7287	DIAGNOSIS IS ELIGIBLE FOR WORKERS COMPENSATION/AUTO PAYOR
7288	SMARTSUSPENSE FLAG
7289	SMARTSUSPENSE MONITOR
7291	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE
7499	INVALID R.A.P. REFERRING PROVIDER NUMBER
7500	YOUR CLAIM IS BEING REVIEWED
7501	YOUR CLAIM IS BEING REVIEWED
7502	MEMBER LOCKED IN TO A SPECIFIC PROVIDER
7503	MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALERT SET ON THE CLAIM. PLEASE USE APPROPRIATE DD, LD, HD, ER, LR, PA, PG, MC, TD
7504	MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE M0, P0 OR R0 AND RESUBMIT.
7505	MISSING/INVALID PRODUR OUTCOME CODE. PLEASE USE 1A-1G, 2A OR 2B
7506	RESPONSE CLAIM. ORIGINAL CLAIM FAILED A NON-OVERRIDEABLE ALERT CONTACT, COLLEGE OF PHARMACY TO RECEIVE PRIOR AUTHORIZATION.
7507	VALID OUTCOME CODE OF (NOT FILLED) RECEIVED. RESPONSE ACCEPTED, CLAIM REJECTED.
7508	QUANTITY DISPENSED ON RESPONSE CLAIM SAME AS ORIGINAL CLAIM
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW
7834	RECIPIENT SERVICES COVERED BY PMHP PLAN
8000	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO BILLING ERROR.
8001	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER
8002	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN MEDICARE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8003	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO KEYING ERROR
8004	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY
8005	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO SPENDDOWN
8006	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO MISCELLANEOUS ERROR
8007	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO BILLING ERROR
8008	PROVIDER REQUESTED CLAIM ADJUSTMENT DUE TO MISC OR UNSPECIFIED ERROR
8019	PROVIDER REQUESTED A FULL OFFSET DUE TO A MISCELLANEOUS OR UNSPECIFIED ERROR
8020	SURS INITIATED A FULL OFFSET DUE TO A DUPLICATE PAYMENT
8021	SURS INITIATED A FULL OFFSET DUE TO WRONG PROVIDER
8022	SURS INITIATED A FULL OFFSET DUE TO WRONG MEMBER NUMBER
8023	SURS INITIATED A FULL OFFSET DUE TO WRONG NDC/PROCEDURE CODE/MODIFIER CODE
8024	SURS INITIATED A FULL OFFSET DUE TO WRONG UNITS OF SERVICE
8025	SURS INITIATED A FULL OFFSET DUE TO WRONG PATIENT LIABILITY AMOUNT
8026	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM ANOTHER INSURANCE
8027	SURS INITIATED A FULL OFFSET DUE TO PAYMENT IN FULL FROM MEDICARE
8028	SURS INITIATED A FULL OFFSET DUE TO WRONG DATE(S) OF SERVICE
8030	PROVIDER REQUESTED OFFSET DUE TO BILLING ERROR
8031	PROVIDER REQUESTED OFFSET DUE TO OTHER INSURANCE
8032	PROVIDER REQUESTED OFFSET DUE MEDICARE
8033	PROVIDER REQUESTED OFFSET DUE TO PATIENT LIABILITY
8034	PROVIDER REQUESTED OFFSET DUE TO SPENDDOWN
8035	PROVIDER REQUESTED OFFSET DUE TO AUTO LIABILITY
8036	PROVIDER REQUESTED OFFSET DUE TO WORKERS COMP
8037	PROVIDER REQUESTED CLAIM VOID DUE TO BILLING ERROR
8038	PROVIDER REQUESTED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8059	PROVIDER SENT A FULL REFUND DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8060	PROVIDER SENT REFUND DUE TO BILLING ERROR.
8061	PROVIDER SENT REFUND DUE TO CLAIMS PROCESSING ERROR
8062	PROVIDER SENT REFUND DUE TO DUPLICATE PAYMENT
8063	PROVIDER SENT REFUND DUE TO EFT DEPOSIT ERROR.
8064	PROVIDER SENT REFUND DUE TO MEDICARE.
8065	PROVIDER SENT REFUND DUE TO OFMQ REVIEW.
8066	PROVIDER SENT REFUND DUE TO OTHER INSURANCE
8067	PROVIDER SENT REFUND DUE TO SURS REVIEW
8068	PROVIDER SENT REFUND PAYMENT DUE TO SURS REVIEW
8069	PROVIDER SENT REFUND DUE TO LEGAL SETTLEMENT
8070	PROVIDER SENT REFUND DUE TO MEDICAID FRAUD
8071	PROVIDER SENT REFUND PAYMENT DUE TO MEDICAID FRAUD
8072	PROVIDER SENT REFUND DUE TO AUTO LIABILITY
8073	PROVIDER SENT REFUND DUE TO WORKERS COMP.
8074	PROVIDER SENT REFUND FOR CLAIM NOT IN HISTORY
8075	PROVIDER SENT REFUND DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8082	NON-CLAIM SPECIFIC REFUND DUE TO BILLING ERROR
8083	NON-CLAIM SPECIFIC REFUND DUE TO OTHER INSURANCE
8084	NON-CLAIM SPECIFIC REFUND DUE TO SURS
8085	NON-CLAIM SPECIFIC REFUND DUE TO MISC OR UNSPECIFIED ERROR
8090	AHCA REQUESTED REFUND DUE TO ACCOUNTS RECEIVABLE
8091	AHCA REQUESTED REFUND DUE TO AUDIT DIVISION REVIEW
8092	AHCA REQUESTED REFUND DUE TO BILLING ERROR
8093	AHCA REQUESTED REFUND DUE TO CLAIMS PROCESSING ERROR
8094	AHCA REQUESTED REFUND DUE TO WRONG PROVIDER PAID/EFT ERROR
8095	AHCA REQUESTED REFUND DUE TO MEDICARE
8096	AHCA REQUESTED REFUND DUE TO OFMQ
8097	AHCA REQUESTED REFUND DUE TO OTHER INSURANCE
8098	AHCA REQUESTED REFUND DUE TO SURS REVIEW

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8099	AHCA REQUESTED REFUND DUE TO LEGAL SETTLEMENT
8100	AHCA REQUESTED REFUND DUE TO MEDICAID FRAUD
8110	AHCA INITIATED OFFSET DUE AUDIT DIVISION REVIEW
8111	AHCA INITIATED OFFSET DUE TO CALL CENTER
8112	AHCA INITIATED OFFSET DUE TO CLAIMS RESOLUTION
8113	AHCA INITIATED OFFSET DUE TO COST SETTLEMENT ADJUSTMENT
8114	AHCA INITIATED OFFSET DUE TO CUSTOMER SERVICE
8115	AHCA INITIATED OFFSET DUE TO SERVICES AFTER DEATH OF MEMBER
8116	AHCA INITIATED OFFSET DUE TO DHS/CHILD WELFARE
8117	AHCA INITIATED OFFSET DUE TO DHS/DCYS
8118	AHCA INITIATED OFFSET DUE TO DHS/DDSD
8119	AHCA INITIATED OFFSET DUE TO DISPROPORTIONATE SHARE ADJUS
8120	AHCA INITIATED OFFSET DUE TO DRUG REBATE
8121	AHCA INITIATED OFFSET DUE TO FINANCIAL MANAGEMENT DIVISION REVIEW
8122	AHCA INITIATED OFFSET DUE TO FOHC
8123	AHCA INITIATED OFFSET DUE TO JUVENILE JUSTICE
8124	AHCA INITIATED OFFSET DUE TO KEYING ERROR
8125	AHCA INITIATED OFFSET DUE TO LEGAL SETTLEMENT
8126	AHCA INITIATED OFFSET DUE TO MEDICAID FRAUD
8127	AHCA INITIATED OFFSET DUE TO MEDICAL REVIEW
8128	AHCA INITIATED OFFSET DUE TO MEDICARE
8129	AHCA INITIATED OFFSET DUE TO OFMQ REVIEW
8130	AHCA INITIATED OFFSET DUE TO PHARMACY REVIEW
8131	AHCA INITIATED OFFSET DUE TO PROCESSING ERROR
8132	AHCA INITIATED OFFSET DUE TO SURS REVIEW
8133	AHCA INITIATED OFFSET DUE TO WRONG PROVIDER PAID
8134	AHCA INITIATED OFFSET DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8135	EDS INITIATED OFFSET DUE TO PROCESSING ERROR
8136	EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR
8137	AHCA INITIATED PARTIAL CLAIM OFFSET DUE TO OFMQ REVIEW
8138	AHCA INITIATED OFFSET DUE TO PRESCRIBING PROVIDER EXCLUDED
8139	AHCA INITIATED OFFSET OF FFS CLAIM FOR MEMBER ENROLLED IN MANAGED CARE
8140	AHCA INITIATED OFFSET OF OUT-PATIENT CLAIM DUE TO PAID IN-PATIENT CLAIM
8150	AHCA INITIATED ADDITIONAL PAYMENT DUE TO CALL CENTER
8151	AHCA INITIATED ADDITIONAL PAYMENT DUE TO CLAIMS RESOLUTION
8152	AHCA INITIATED ADDITIONAL PAYMENT DUE TO DHS/CHILD WELFARE
8153	AHCA INITIATED ADDITIONAL PAYMENT DUE TO DHS/DDSD
8154	AHCA INITIATED ADDITIONAL PAYMENT DUE TO DISPROPORTIONATE SHARE
8155	AHCA INITIATED ADDITIONAL PAYMENT DUE TO FINANCIAL MANAGEMENT REVIEW
8156	AHCA INITIATED ADDITIONAL PAYMENT DUE TO FOHC
8157	AHCA INITIATED ADDITIONAL PAYMENT DUE TO KEYING ERROR
8158	AHCA INITIATED ADDITIONAL PAYMENT DUE TO MEDICAL REVIEW
8159	AHCA INITIATED ADDITIONAL PAYMENT DUE TO MEDICAL AUTHORIZATION
8160	AHCA INITIATED ADDITIONAL PAYMENT DUE TO MEDICARE
8161	AHCA INITIATED ADDITIONAL PAYMENT DUE TO OTHER INSURANCE
8162	AHCA INITIATED ADDITIONAL PAYMENT DUE TO PATIENT LIABILITY
8163	AHCA INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR
8164	AHCA INITIATED ADDITIONAL PAYMENT DUE TO RATE CHANGE
8165	AHCA INITIATED ADDTNL PYMNT DUE TO MISC OR UNSPEC ERROR
8166	EDS INITIATED ADDITIONAL PAYMENT DUE TO PROCESSING ERROR
8167	EDS INITIATED ADJUSTMENTS DUE TO PROCESSING ERROR.
8179	VOID OUTPATIENT CLAIM OF INPATIENT DUPLICATE
8180	MASS ADJUSTMENT - INPATIENT HOSPITAL RATE CHANGE
8181	MASS ADJUSTMENT - OUTPATIENT HOSPITAL RATE CHANGE
8182	MASS ADJUSTMENT- INDIAN HOSPITAL RATE CHANGE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8183	MASS ADJUSTMENT - RURAL HEALTH CLINIC RATE CHANGE
8184	MASS ADJUSTMENT - PROCEDURE CODE RATE CHANGE
8185	MASS ADJUSTMENT - RETROACTIVE RATE CHANGE
8186	MASS ADJUSTMENT PROVIDER BILLING ERROR (RATE CHANGE).
8187	OTHER REQUEST FOR MASS ADJUSTMENT
8188	VOID TRANSACTIONS - MASS ADJUSTMENT
8189	MASS ADJUSTMENT - VOID TRANSACTIONS - REFUND RECEIVED
8190	MASS ADJUSTMENT - VOID TRANSACTIONS - WARRANT CANCELLED
8191	MASS ADJUSTMENT - VOID TRANSACTIONS OTHER REQUEST
8200	TPL PRIVATE HEALTH INSURANCE - CARRIER
8201	TPL PRIVATE HEALTH INSURANCE - PROVIDER
8202	TPL PRIVATE HEALTH INSURANCE - MEMBER
8203	AUTO LIABILITY - CARRIER
8204	AUTO LIABILITY - PROVIDER
8205	AUTO LIABILITY - MEMBER
8206	NON-AUTO LIABILITY - CARRIE
8207	NON-AUTO LIABILITY - PROVIDER
8208	NON-AUTO LIABILITY - MEMBER
8209	WORKERS COMP - CARRIER
8210	WORKERS COMP - PROVIDER
8212	PROBATES ESTATE
8213	INCOME PENSION TRUST RECOVERIES
8214	VICTIMS RESTITUTION
8217	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8220	SAVE FOR FUTURE USE * TEMPORARILY USE FOR VOIDS *
8224	SAVE FOR FUTURE USE.
8225	CAPITATION - DEATH OF MEMBER
8226	CAPITATION - MEMBER INCARCERATED
8227	CAPITATION - EPSDT CLAIM
8228	CAPITATION - MEMBER ENROLLED IN ERROR
8229	CAPITATION - FAMILY PLANNING
8230	CAPITATION - INCORRECT RATE CATEGO
8231	CAPITATION - DEMOGRAPHIC CHANGE
8232	CAPITATION - OTHER
8234	TPL VENDOR VOID
8240	ADJUSTMENT GENERATED DUE TO SURS REVIEW
8241	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY
8242	ADJUSTMENT GENERATED DUE TO RATE CHANGE
8244	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE
8245	POINT OF SALE
8246	POINT OF SALE REVERSAL
8286	RECIPIENT HAS VERIFIED INSURANCE COMPANY
8287	CHECK HISTORY MASS VOID
8288	AUTO RECOUPMENT, SYSTEM CHARGE
8289	AUTO RECOUPMENT, SYSTEM ERROR
8290	AHCA ORDERED REPROCESSED CLAIMS
8291	COURT ORDERED SETTLEMENT
8292	DISPROPORTIONATE SHARE PAYMENT
8293	CLAIM ADJUSTMENT VIA TPL BILLING FILE
8294	CREDIT BALANCE FROM EDS
8295	CHANGE IN PATIENT RESOURCES
8296	INSTITUTIONAL CARE PROVIDER CHANGE OF OWNERSHIP
8297	OUTPATIENT CLAIM CONFLICT WITH INPATIENT STAY
8298	LTCF OV TRANSACTION CODE CREDIT
8299	LTCF OV PROVIDER DECREASE BY STATE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8300	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE.
8301	A PAYOUT HAS BEEN ESTABLISHED FOR THE PROVIDER. THE REIMBURSEMENT HAS BEEN EXCLUDED FROM THE CHECKWRITE
8302	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER REFUND. THE REIMBURSEMENT IS INCLUDED IN THE CHECKWRITE
8303	A PAYOUT IS DUE TO THE PROVIDER AS A RESULT OF OVER PAYMENT. THE REIMBURSEMENT HAS BEEN EXCLUDED FROM THE CHECKWRITE.
8304	PAYOUT DUE TO ADVANCE. PAYMENT INCLUDED IN CHECKWRITE.
8305	PAYOUT DUE TO ADVANCE. PAYMENT EXCLUDED FROM CHECKWRITE.
8306	CHECK RECEIVED BY EDS FOR CLAIM ADJUSTMENT ON A PREVIOUSLY ADJUSTED CLAIM. AMOUNT OF REFUND BEING RETURNED TO PROVIDER
8307	PAYOUT EXCLUDED FROM CHECKWRITE
8308	PAYOUT DUE TO HOSPITAL SUPPLEMENTAL GME ADJUSTMENT
8309	PAYOUT DUE TO MANAGED CARE - RESIDENT PCP PAYMENT
8310	PAYOUT DUE TO MANAGED CARE - RESIDENT DELIVERY PAYMENT
8311	PAYOUT DUE TO MANAGED CARE - ABD RISK BASED PAYM
8312	PAYOUT DUE TO MANAGED CARE - SP/ABD QUARTERLY PAYMENT
8313	PAYOUT DUE TO MANAGED CARE - EPSDT BONUS PAYMENT
8314	PAYOUT DUE TO MANAGED CARE - CUSTODY INDICATOR ERROR
8315	PAYOUT DUE TO MANAGED CARE - ENROLLMENT ERROR
8316	PAYOUT DUE TO MANAGED CARE - OTHER
8317	PAYOUT DUE TO MEDICAL AUTHORIZATION UNIT REVIEW-CCU
8318	PAYOUT DUE TO LONG TERM CARE FACILITY CERTIFICATION DATE ERROR
8319	PAYOUT DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR
8320	PAYOUT DUE TO PATIENT LIABILITY ERROR
8321	PAYOUT DUE TO PATIENT SPENDDOWN ERROR
8322	PAYOUT DUE TO ENHANCED RATE-OUT OF STATE RTC SERVICES
8323	PAYOUT DUE TO NON-EMERGENCY TRANSPORTATION
8324	PAYOUT DUE TO PROGRAM RULES
8325	PAYOUT DUE TO GAS SURCHARGE
8326	PAYOUT DUE TO CORRECTION TO ACCOUNTS RECEIVABLE PROCESSED
8327	PAYOUT DUE TO DHS/DDSD SUPPORTED LIVING PROGRAM AUDIT
8328	PAYOUT DUE TO DHS/DDSD AUDIT
8329	PAYOUT PROCESSED FROM STATE ONLY FUNDS
8330	PAYOUT DUE TO ELIGIBILITY NOT ON FILE
8331	PAYOUT DUE TO CLAIM TOO OLD TO PROCESS
8332	PAYOUT DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8336	RETROACTIVE INTEREST PAYMENT
8399	THIS ACTION IS THE RESULT OF A STOP PAYMENT. A MANUAL CHECK HAS BEEN ISSUED.
8400	ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS
8401	DUE TO A CHECK ADVANCE, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR FUTURE PAYMENTS.
8402	DUE TO AN IRS LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8403	DUE TO A GARNISHMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8404	DUE TO A LIABILITY AND CASUALTY LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8405	DUE TO A LIEN, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8406	DUE TO TAX ASSESSMENT (31%), AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8407	RELEASE OF LIEN RECEIVED BY LIEN HOLDER

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8408	DECREASE TO ORIGINAL LIEN AMOUNT
8409	INCREASE TO ORIGINAL LIEN AMOUNT
8420	AS THE RESULT OF AN AUDIT DIVISION REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8421	AS THE RESULT OF CLAIMS PROCESSING ERROR, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8422	AS THE RESULT OF A COST SETTLEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8423	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/DDSD AUDIT
8424	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DHS/CHILD WELFARE.
8425	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO JUVENILE JUSTICE
8426	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DISPROPORTIONATE SHARE ADJUSTMENT
8427	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO DRUG REBATE
8428	AS THE RESULT OF A FINANCIAL MANAGEMENT REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8429	AS THE RESULT OF A LEGAL SETTLEMENT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8430	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO LONG TERM CARE FACILITY CLAIM PROCESSING ERROR
8431	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MANAGED CARE ADJUSTMENTS
8432	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAID FRAUD
8433	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MEDICAL DIVISION REVIEW
8434	AS THE RESULT OF AN OFMQ REVIEW, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8435	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT LIABILITY ERROR
8436	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PATIENT SPENDDOWN ERROR
8437	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO PHARMACY DIVISION REVIEW
8438	AS THE RESULT OF A SURS AUDIT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8439	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO THIRD PARTY LIABILITY
8450	DUE TO A TRANSFER OF ACCOUNT, AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8451	ADJUSTMENT REQUEST FOR A CLAIM TOO OLD TO PROCESS, AN ACCOUNT RECEIVABLE HAS BEEN ESTABLISHED. THE AMOUNT WILL BE DEDUCTED FROM YOUR PAYMENTS.
8452	AN ACCOUNTS RECEIVABLE HAS BEEN ESTABLISHED DUE TO MISCELLANEOUS OR UNSPECIFIED ERROR
8453	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND INCREASED THIS ACCOUNTS RECEIVABLE.
8454	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG AMOUNT. WE HAVE MADE CORRECTION AND DECREASED THIS ACCOUNTS RECEIVABLE.
8455	THIS ACCOUNTS RECEIVABLE WAS ESTABLISHED FOR THE WRONG PROVIDER. WE HAVE CORRECTED THE ACTION AND DECREASED THIS ACCOUNTS RECEIVABLE.
8456	A CASH RECEIPT WAS APPLIED TO AND DECREASED THIS ACCOUNTS RECEIVABLE
8457	AN OVER REFUND HAS BEEN APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE
8458	A STOP PAYMENT CHECK WAS APPLIED AND DECREASED THIS ACCOUNTS RECEIVABLE
8459	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO FINANCIAL DIVISION REVIEW
8460	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO FINANCIAL DIVISION REVIEW
8461	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO AUDIT DIVISION REVIEW
8462	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO AUDIT DIVISION REVIEW
8463	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO SURS REVIEW
8464	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED DUE TO SURS REVIEW
8465	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED DUE TO INTEREST BEING APPLIED
8466	THIS ACCOUNTS RECEIVABLE HAS BEEN DECREASED BY A MISCELLANEOUS ACTION
8467	THIS ACCOUNTS RECEIVABLE HAS BEEN INCREASED BY A MISCELLANEOUS ACTION

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8468	THIS ACCOUNTS RECEIVABLE HAS BEEN WRITTEN OFF
8469	THIS ACCOUNTS RECEIVABLE WAS DECREASED BY A CLAIM OFFSET
8480	AHCA INITIATED OFFSET DUE TO CLAIMCHECK INCIDENTAL TO PRIMARY PROCEDURE
8481	AHCA INITIATED OFFSET DUE TO CLAIMCHECK MUTUALLY EXCLUSIVE
8482	AHCA INITIATED OFFSET DUE TO CLAIMCHECK PRE-OP/POST-OP
8483	AHCA INITIATED OFFSET DUE TO CLAIMCHECK MEDICAL/EVALUATION VISIT
8484	AHCA INITIATED OFFSET DUE TO CLAIMCHECK NEW VISIT FREQUENCY
8500	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM A COURT ORDER
8501	PAYMENT WITHHELD DUE TO AN IRS LEVY ESTABLISHED
8502	PAYMENT WITHHELD DUE TO A LIEN THAT WAS ESTABLISHED FROM OTHER LEGAL ENTITY
8510	CYCLE ACTIVITY
8511	DECREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER
8512	DECREASE TO ORIGINAL LIEN AMOUNT DUE TO PAYMENT RECEIVED
8513	INCREASE TO ORIGINAL LIEN AMOUNT RECEIVED BY LIEN HOLDER
8514	RELEASE OF LIEN RECEIVED BY LIEN HOLDER
8515	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION
8600	01-M/I BIN
8601	02-M/I VERSION NUMBER
8602	03-M/I TRANSACTION CODE
8603	04-M/I PROCESSOR CONTROL NUMBER
8604	05-M/I PHARMACY NUMBER
8605	06-M/I GROUP NUMBER
8606	07-M/I CARDHOLDER ID NUMBER
8607	08-M/I PERSON CODE
8608	09-M/I BIRTH DATE
8609	1C-M/I SMOKER/NON-SMOKER CODE
8610	1E-M/I PRESCRIBER LOCATION CODE
8611	10-M/I PATIENT GENDER CODE
8612	11-M/I PATIENT RELATIONSHIP CODE
8613	12-M/I PATIENT LOCATION
8614	13-M/I OTHER COVERAGE CODE
8615	14-M/I ELIGIBILITY CLARIFICATION CODE
8616	15-M/I DATE OF SERVICE
8617	16-M/I PRESCRIPTION/SERVICE REFERENCE NUMBER
8618	17-M/I FILL NUMBER
8619	19-M/I DAYS SUPPLY
8620	2C-M/I PREGNANCY INDICATOR
8621	2E-M/I PRIMARY CARE PROVIDER ID QUALIFIER
8622	20-M/I COMPOUND CODE
8623	21-M/I PRODUCT/SERVICE ID
8624	22-M/I DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE
8625	23-M/I INGREDIENT COST SUBMITTED
8626	25-M/I PRESCRIBER ID
8627	26-M/I UNIT OF MEASURE
8628	28-M/I DATE PRESCRIPTION WRITTEN
8629	29-M/I NUMBER REFILLS AUTHORIZED
8630	3A-M/I REQUEST TYPE
8631	3B-M/I REQUEST PERIOD DATE-BEGIN
8632	3C-M/I REQUEST PERIOD DATE-END
8633	3D-M/I BASIS OF REQUEST
8634	3E-M/I AUTHORIZED REPRESENTATIVE FIRST NAME
8635	3F-M/I AUTHORIZED REPRESENTATIVE LAST NAME
8636	3G-M/I AUTHORIZED REPRESENTATIVE STREET ADDRESS
8637	3H-M/I AUTHORIZED REPRESENTATIVE CITY ADDRESS
8638	3J-M/I AUTHORIZED REPRESENTATIVE STATE/PROVINCE ADDRESS

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8639	3K-M/I AUTHORIZED REPRESENTATIVE ZIP/POSTAL ZONE
8640	3M-M/I PRESCRIBER PHONE NUMBER
8641	3N-M/I PRIOR AUTHORIZED NUMBER ASSIGNED
8642	3P-M/I AUTHORIZATION NUMBER
8643	3R-PRIOR AUTHORIZATION NOT REQUIRED
8644	3S-M/I PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION
8645	3T-ACTIVE PRIOR AUTHORIZATION EXISTS RESUBMIT AT EXPIRATION OF PRIOR AUTH
8646	3W-PRIOR AUTHORIZATION IN PROCESS
8647	3X-AUTHORIZATION NUMBER NOT FOUND
8648	3Y-PRIOR AUTHORIZATION DENIED
8649	32-M/I LEVEL OF SERVICE
8650	33-M/I PRESCRIPTION ORIGIN CODE
8651	34-M/I SUBMISSION CLARIFICATION CODE
8652	35-M/I PRIMARY CARE PROVIDER ID
8653	38-M/I BASIS OF COST
8654	39-M/I DIAGNOSIS CODE
8655	4C-M/I COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT
8656	4E-M/I PRIMARY CARE PROVIDER LAST NAME
8657	40-PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE
8658	41-SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER
8659	5C-M/I OTHER PAYER COVERAGE TYPE
8660	5E-M/I OTHER PAYER REJECT COUNT
8661	50-NON-MATCHED PHARMACY NUMBER
8662	51-NON-MATCHED GROUP ID
8663	52-NON-MATCHED CARDHOLDER ID
8664	53-NON-MATCHED PERSON CODE
8665	54-NON-MATCHED PRODUCT/SERVICE ID NUMBER
8666	55-NON-MATCHED PRODUCT PACKAGE SIZE
8667	56-NON-MATCHED PRESCRIBER ID
8668	58-NON-MATCHED PRIMARY PRESCRIBER
8669	6C-M/I OTHER PAYER ID QUALIFIER
8670	6E-M/I OTHER PAYER REJECT CODE
8671	60-PRODUCT/SERVICE NOT COVERED FOR PATIENT AGE
8672	61-PRODUCT/SERVICE NOT COVERED FOR PATIENT GENDER
8673	62-PATIENT/CARD HOLDER ID NAME MISMATCH
8674	63-INSTITUTIONALIZED PATIENT PRODUCT/SERVICE ID NOT COVERED
8675	64-CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION
8676	65-PATIENT IS NOT COVERED
8677	66-PATIENT AGE EXCEEDS MAXIMUM AGE
8678	67-FILLED BEFORE COVERAGE EFFECTIVE
8679	68-FILLED AFTER COVERAGE EXPIRED
8680	69-FILLED AFTER COVERAGE TERMINATED
8681	7C-M/I OTHER PAYER ID
8682	7E-M/I DUR/PPS CODE COUNTER
8683	70-PRODUCT/SERVICE NOT COVERED
8684	71-PRESCRIBER IS NOT COVERED
8685	72-PRIMARY PRESCRIBER IS NOT COVERED
8686	73-REFILLS ARE NOT COVERED
8687	74-OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE
8688	75-PRIOR AUTHORIZATION REQUIRED
8689	76-PLAN LIMITATIONS EXCEEDED
8690	77-DISCONTINUED PRODUCT/SERVICE ID NUMBER
8691	78-COST EXCEEDS MAXIMUM
8692	79-REFILL TOO SOON
8693	8C-M/I FACILITY ID

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8694	8E-M/I DUR/PPS LEVEL OF EFFORT
8695	80-DRUG-DIAGNOSIS MISMATCH
8696	81-CLAIM TOO OLD
8697	82-CLAIM IS POST-DATED
8698	83-DUPLICATE PAID/CAPTURED CLAIM
8699	84-CLAIM HAS NOT BEEN PAID/CAPTURED
8700	85-CLAIM NOT PROCESSED
8701	86-SUBMIT MANUAL REVERSAL
8702	87-REVERSAL NOT PROCESSED
8703	88-DUR REJECT ERROR
8704	89-REJECTED CLAIM FEES PAID
8705	90-HOST HUNG UP
8706	91-HOST RESPONSE ERROR
8707	92-SYSTEM UNAVAILABLE/HOST UNAVAILABLE
8708	95-TIME OUT
8709	96-SCHEDULED DOWNTIME
8710	97-PAYER UNAVAILABLE
8711	98-CONNECTION TO PAYER IS DOWN
8712	99-HOST PROCESSING ERROR
8713	AA-PATIENT SPENDDOWN NOT MET
8714	AB-DATE WRITTEN IS AFTER DATE FILLED
8715	AC-PRODUCT NOT COVERED NON-PARTICIPATING MANUFACTURER
8716	AD-BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM TYPE
8717	AE-QMB (QUALIFIED MEDICARE BENEFICIARY)-BILL
8718	AF-PATIENT ENROLLED UNDER MANAGED CARE
8719	AG-DAYS SUPPLY LIMITATION FOR PRODUCT/SERVICE
8720	AH-UNIT DOSE PACKAGING ONLY PAYABLE FOR NURSING HOME RECIPIENTS
8721	AJ-GENERIC DRUG REQUIRED
8722	AK-M/I SOFTWARE VENDOR/CERTIFICATION ID
8723	AM-M/I SEGMENT IDENTIFICATION
8724	A9-M/I TRANSACTION COUNT
8725	BE-M/I PROFESSIONAL SERVICE FEE SUBMITTED
8726	B2-M/I SERVICE PROVIDER ID QUALIFIER
8727	CA-M/I PATIENT FIRST NAME
8728	CB-M/I PATIENT LAST NAME
8729	CC-M/I CARDHOLDER FIRST NAME
8730	CD-M/I CARDHOLDER LAST NAME
8731	CE-M/I HOME PLAN
8732	CF-M/I EMPLOYER NAME
8733	CG-M/I EMPLOYER STREET ADDRESS
8734	CH-M/I EMPLOYER CITY ADDRESS
8735	CI-M/I EMPLOYER STATE/PROVINCE ADDRESS
8736	CJ-M/I EMPLOYER ZIP POSTAL ZONE
8737	CK-M/I EMPLOYER PHONE NUMBER
8738	CL-M/I EMPLOYER CONTACT NAME
8739	CM-M/I PATIENT STREET ADDRESS
8740	CN-M/I PATIENT CITY ADDRESS
8741	CO-M/I PATIENT STATE/PROVINCE ADDRESS
8742	CP-M/I PATIENT ZIP/POSTAL ZONE
8743	CQ-M/I PATIENT PHONE NUMBER
8744	CR-M/I CARRIER ID
8745	CW-M/I ALTERNATE ID
8746	CX-M/I PATIENT ID QUALIFIER
8747	CY-M/I PATIENT ID
8748	CZ-M/I EMPLOYER ID

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8749	DC-M/I DISPENSING FEE SUBMITTED
8750	DN-M/I BASIS OF COST DETERMINATION
8751	DQ-M/I USUAL AND CUSTOMARY CHARGE
8752	DR-M/I PRESCRIBER LAST NAME
8753	DT-M/I UNIT DOSE INDICATOR
8754	DU-M/I GROSS AMOUNT DUE
8755	DV-M/I OTHER PAYER AMOUNT PAID
8756	DX-M/I PATIENT PAID AMOUNT SUBMITTED
8757	DY-M/I DATE OF INJURY
8758	DZ-M/I CLAIM/REFERENCE ID
8759	EA-M/I ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE
8760	EB-M/I ORIGINALLY PRESCRIBED QUANTITY
8761	EC-M/I COMPOUND INGREDIENT COMPONENT COUNT
8762	ED-M/I COMPOUND INGREDIENT QUANTITY
8763	EE-M/I COMPOUND INGREDIENT DRUG COST
8764	EF-M/I COMPOUND DOSAGE FORM DESCRIPTIN CODE
8765	EG-M/I COMPOUND DISPENSING UNIT FORM INDICATOR
8766	EH-M/I COMPOUND ROUTE OF ADMINISTRATION
8767	EJ-M/I ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER
8768	EK-M/I SCHEDULED PRESCRIPTION ID NUMBER
8769	EM-M/I PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER
8770	EN-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER
8771	EP-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE
8772	ER-M/I PROCEDURE MODIFIER CODE
8773	ET-M/I QUANTITY PRESCRIBED
8774	EU-M/I PRIOR AUTHORIZATION TYPE CODE
8775	EV-M/I PRIOR AUTHORIZATION NUMBER SUBMITTED
8776	EW-M/I INTERMEDIARY AUTHORIZATION TYPE ID
8777	EX-M/I INTERMEDIARY AUTHORIZATION ID
8778	EY-M/I PROVIDER ID QUALIFIER
8779	EZ-M/I PRESCRIBER ID QUALIFIER
8780	E1-M/I PRODUCT/SERVICE ID QUALIFIER
8781	E3-M/I INCENTIVE AMOUNT SUBMITTED
8782	E4-M/I REASON FOR SERVICE CODE
8783	E5-M/I PROFESSIONAL SERVICE CODE
8784	E6-M/I RESULT OF SERVICE CODE
8785	E7-M/I QUANTITY DISPENSED
8786	E8-M/I OTHER PAYER DATE
8787	E9-M/I PROVIDER ID
8788	FO-M/I PLAN ID
8789	GE-M/I PERCENTAGE SALES TAX AMOUNT SUBMITTED
8790	HA-M/I FLAT SALES TAX AMOUNT SUBMITTED
8791	HB-M/I OTHER PAYER AMOUNT PAID COUNT
8792	HC-M/I OTHER PAYER AMOUNT PAID QUALIFIER
8793	HD-M/I DISPENSING STATUS
8794	HE-M/I PERCENTAGE SALES TAX RATE SUBMITTED
8795	HF-M/I QUANTITY INTENDED TO BE DISPENSED
8796	HG-M/I DAYS SUPPLY INTENDED TO BE DISPENSED
8797	H1-M/I MEASUREMENT TIME
8798	H2-M/I MEASUREMENT DIMENSION
8799	H3-M/I MEASUREMENT UNIT
8800	H4-M/I MEASUREMENT VALUE
8801	H5-M/I PRIMARY CARE PROVIDER LOCATION CODE
8802	H6-M/I DUR CO-AGENT ID
8803	H7-M/I OTHER AMOUNT CLAIMED SUBMITTED COUNT

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8804	H8-M/I OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER
8805	H9-M/I OTHER AMOUNT CLAIMED SUBMITTED
8806	JE-M/I PERCENTAGE SALES TAX BASIS SUBMITTED
8807	J9-M/I DUR CO-AGENT ID QUALIFIER
8808	KE-M/I COUPON TYPE
8809	M1-PATIENT NOT COVERED IN THIS AID CATEGORY
8810	M2-RECIPIENT LOCKED IN
8811	M3-HOST PA/MC ERROR
8812	M4-PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT EXCEEDED
8813	M5-REQUIRES MANUAL CLAIM
8814	M6-HOST ELIGIBILITY ERROR
8815	M7-HOST DRUG FILE ERROR
8816	M8-HOST PROVIDER FILE ERROR
8817	ME-M/I COUPON NUMBER
8818	MZ-ERROR OVERFLOW
8819	NE-M/I COUPON VALUE AMOUNT
8820	NN-TRANSACTION REJECTED AT SWITCH OR INTERMEDIARY
8821	PA-PA EXHAUSTED/NOT RENEWABLE
8822	PB-INVALID TRANSACTION COUNT FOR THIS TRANSACTION CODE
8823	PC-M/I CLAIM SEGMENT
8824	PD-M/I CLINICAL SEGMENT
8825	PE-M/I COB/OTHER PAYMENTS SEGMENT
8826	PF-M/I COMPOUND SEGMENT
8827	PG-M/I COUPON SEGMENT
8828	PH-M/I DUR/PPS SEGMENT
8829	PJ-M/I INSURANCE SEGMENT
8830	PK-M/I PATIENT SEGMENT
8831	PM-M/I PHARMACY PROVIDER SEGMENT
8832	PN-M/I PRESCRIBER SEGMENT
8833	PP-M/I PRICING SEGMENT
8834	PR-M/I PRIOR AUTHORIZATION SEGMENT
8835	PS-M/I TRANSACTION HEADER SEGMENT
8836	PT-M/I WORKERS COMPENSATION SEGMENT
8837	PV-NON-MATCHED ASSOCIATED PRESCRIPTION/SERVICE DATE
8838	PW-NON-MATCHED EMPLOYER ID
8839	PX-NON-MATCHED OTHER PAYER ID
8840	PY-NON-MATCHED UNIT FORM/ROUTE OF ADMINISTRATION
8841	PZ-NON-MATCHED UNIT OF MEASURE TO PRODUCT/SERVICE ID
8842	P1-ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER NOT FOUND
8843	P2-CLINICAL INFORMATION COUNTER OUT OF SEQUENCE
8844	P3-COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8845	P4-COORDINATION OF BENEFITS/OTHER PAYMENT COUNT DOES NOT MATCH # OF REPETITIONS
8846	P5-COUPON EXPIRED
8847	P6-DATE OF SERVICE PRIOR TO DATE OF BIRTH
8848	P7-DIAGNOSIS CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8849	P8-DUR/PPS CODE COUNTER OUT OF SEQUENCE
8850	P9-FIELD IS NON-REPEATABLE
8851	RA-PA REVERSAL OUT OF ORDER
8852	RB-MULTIPLE PARTIALS NOT ALLOWED
8853	RC-DIFFERENT DRUG ENTITY BETWEEN PARTIAL AND COMPLETION
8854	RD-MISMATCHED CARDHOLDER/GROUP ID-PARTIAL TO COMPLETION
8855	RE-M/I COMPOUND PRODUCT ID QUALIFIER
8856	RF-IMPROPER ORDER OF DISPENSING STATUS, CODE ON PARTIAL FILL TRANSACTION
8857	RG-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE # ON COMPLETION TRANSACTION
8858	RH-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON COMPLETION TRANSACTION

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
8859	RJ-ASSOCIATED PARTIAL FILL TRANSACTION NOT ON FILE
8860	RK-PARTIAL FILL TRANSACTION NOT SUPPORTED
8861	RM-COMPLETION TRANSACTION NOT PERMITTED WITH SAME SERVICE DATE AS PARTIAL TXN
8862	RN-PLAN LIMITS EXCEEDED ON INTENDED PARTIAL FILL VALUES
8863	RP-OUT OF SEQUENCE (P) REVERSAL ON PARTIAL FILL TRANSACTION
8864	RS-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON PARTIAL TRANSACTION
8865	RT-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON PARTIAL TRANSACTION
8866	RU-MANDATORY DATA ELEMENTS MUST OCCUR BEFORE OPTIONAL ELEMENTS IN A SEGMENT
8867	R1-OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8868	R2-OTHER PAYER REJECT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8869	R3-PROCEDURE MODIFIER CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8870	R4-PROCEDURE MODIFIER CODE INVALID FOR PRODUCT/SERVICE ID
8871	R5-PRODUCT/SERVICE ID MUST BE ZERO WHEN PRODUCT/SERVICE ID QUALIFIER EQUALS 06
8872	R6-PRODUCT/SERVICE NOT APPROPRIATE FOR THIS LOCATION
8873	R7-REPEATING SEGMENT NOT ALLOWED IN SAME TRANSACTION
8874	R8-SYNTAX ERROR
8875	R9-VALUE IN GROSS AMOUNT DUE DOES NOT FOLLOW PRICING FORMULAE
8876	SE-M/I PROCEDURE MODIFIER CODE COUNT
8877	TE-M/I COMPOUND PRODUCT ID
8878	UE-M/I COMPOUND INGREDIENT BASIS OF COST DETERMINATION
8879	VE-M/I DIAGNOSIS CODE COUNT
8880	WE-M/I DIAGNOSIS CODE QUALIFIER
8881	XE-M/I CLINICAL INFORMATION COUNTER
8882	ZE-M/I MEASUREMENT DATE
8883	PHARMACY INCENTIVE AMOUNT APPLIED
8998	CLAIM BEING REVIEWED
8999	ADJUSTMENT TO CROSSOVER PAID PRIOR TO 1/1/95. THIS CLAIM HAS BEEN MANUALLY PRICED USING THE MEDICARE COINSURANCE, DEDUCTIBLE AND PSYCHE REDUCTION AMOUNTS.
9000	THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE FLORIDA HEALTH PROGRAM ALLOWED AMOUNT.
9001	REIMBURSEMENT REDUCED BY THE MEMBERS CO-PAYMENT AMOUNT
9002	ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE. PLEASE RESUBMIT WITH AN INVOICE.
9003	NO PAYMENT MADE-TPL/SPENDDOWN IS MORE THAN THE ALLOWED AMOUNT
9004	PERSONAL RESOURCE AMOUNT DEDUCTED FROM THE ALLOWED AMOUNT
9005	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME PROCEDURES ON THE SAME DATE OF SERVICE
9006	THIS ITEM SHOULD NOT BE BILLED WITH THIS PROCEDURE CODE
9007	A PROCEDURE CODE IS REQUIRED WHEN BILLING THIS REVENUE CODE. PLEASE RESUBMIT WITH A PROCEDURE CODE.
9008	LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION. RESUBMIT W/APPROPRIATE AND/OR ADDITIONAL INFORMATION.
9009	SERVICE DENIED. REIMBURSEMENT FOR INPATIENT HOSP CARE LIMITED TO ONCE PER DAY.
9010	SERVICE IS NON-COVERED UNDER THE FLORIDA HEALTH COVERAGE PROGRAM
9011	SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM
9012	WRONG CLAIM FORM SUBMITTED. PLEASE RESUBMIT ON A UB92 CLAIM FORM.
9016	THE OVERHEAD OCCURRENCE DATES BILLED ON THE CLAIM DO NOT AGREE WITH THE DOS BILLED ON THE CLAIM DETAILS. THE FEE WAS APPLIED TO ALL DETAILS.
9017	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PROCEDURE HAS BEEN PAID
9030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT NOT PAYABLE. THE AMOUNT PREVIOUSLY PAID FOR PROCEDURES INCLUDED IN THE VISIT CODE EQUAL THE MAXIMUM ALLOWED.
9031	GLOBAL IMMUNIZATION PROCEDURE CODES NOT PAYABLE WHEN THE AMOUNT PREVIOUSLY REIMBURSED FOR THE RELATED COMPONENT IMMUNIZATION PROCEDURE(S) EQUALS THE REIMBURSE

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
9036	ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVICE EXCEEDS FLORIDA HEALTH COVERAGE PROGRAM ALLOWABLE FOR THE PROCEDURE BILLED.
9040	REIMBURSEMENT IS FOR THE VFC (VACCINE FOR CHILDRENS PROGRAM) VACCINE ADMINISTRATION FEE ONLY
9075	CLAIM DENIED. STERILIZATION CONSENT FORM INCOMPLETE/IMPROPERLY COMPLETED. A STERILIZATION CHECKLIST AND YOUR CLAIM ARE BEING SENT TO YOU WITH THE ERRORS.
9090	DUMMY TEST CODE
9091	TEST - DUMMY CODE NUMBER TWO
9095	DUMMY CONFLICT EOB FOR TEST CASE 22445. INPT HOSPITAL IN CONFLICT WITH OUTPT HOSPITAL CLAIM.
9097	STEP THERAPY DUMMY CODE TEST CASE 22455
9098	TEST CASE 26549 (AUDIT CRITERIA WINDOW)
9100	THIS IS A TEST TO DEMONSTRATE SETTING UP A BUNDLING AUDIT
9101	THIS IS A TEST TO SET UP AN UNBUNDLING AUDIT
9107	FULL SERIES SPINAL X-RAY NOT PAYABLE WHEN AMOUNT PAID FOR COMPONENTS OF THE SERIES WITHIN THE SAME CALENDAR YEAR EQUAL THE ALLOWED AMOUNT.
9111	INTERNAL PROCESSING ERROR - CONTACT SE MANAGER
9175	CLAIM DENIED. MEMBERS SIGNATURE AND DATE OF SIGNATURE IN THE MEMBERS SECTION OF THE CONSENT FORM ARE IN ERROR AND ARE NON CORRECTABLE FIELDS.
9256	TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF \$850.00 PER MONTH, BUT IS NOT PAYABLE WHEN RELATED COMPONENTS HAVE BEEN REIMBURSED FOR THE MAXIMUM AMOUNT
9257	MAXIMUM REIMBURSEMENT FOR OXIMETRY IS \$280.00 PER 30 DAYS. MAXIMUM REIMBURSEMENT HAS BEEN PAID.
9260	PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIES HAVE BEEN PAID WITHIN THE SAME THIRTY DAY PERIOD.
9300	ARCHIVE ADJUSTMENTS
9301	TPL MPI RELATED
9302	REGULAR DISPROPORTIONATE SHARE
9303	RPICC DISPROPORTIONATE
9304	PRIMARY CARE DISPROPORTIONATE
9305	TEACHING (GME) DISPROPORTIONATE
9306	SPECIALTY CARE (TB) DISPROPORTIONATE
9307	MENTAL HEALTH DISPROPORTIONATE
9308	RURAL DISPROPORTIONATE SHARE
9309	CHILDREN DISPROPORTIONATE SHARE
9310	SUPPLEMENTAL PAYMENT
9311	DOS AFTER DATE OF DEATH
9312	NEWBORN SYSTEM DISCREPANCY
9313	PROVIDER SUBMITTED REFUND
9314	RISK RETENTION
9315	TPL RECOVERY MEDICARE PART A
9316	TPL RECOVERY MEDICARE PART B
9317	TPL RECOVERY HEALTH INSURANCE
9318	TPL RECOVERY CARRIER BILLING
9319	TPL RECOVERY TRICARE/CHAMPVA
9320	TPL RECOVERY MPI PROJECT
9321	TPL RECOVERY OTHER
9322	TPL VENDOR/SUBCONTRACTOR RECOVERY 08
9323	TPL VENDOR/SUBCONTRACTOR RECOVERY 09
9324	TPL VENDOR/SUBCONTRACTOR RECOVERY 10
9325	TPL VENDOR/SUBCONTRACTOR RECOVERY 11
9326	TPL RECOVERY CASUALTY
9327	TPL RECOVERY ESTATE
9328	TPL RECOVERY TRUST
9329	TPL VENDOR/SUBCONTRACTOR RECOVERY 15

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
9330	TPL VENDOR/SUBCONTRACTOR RECOVERY 16
9331	TPL VENDOR/SUBCONTRACTOR RECOVERY 17
9332	TPL VENDOR/SUBCONTRACTOR RECOVERY 18
9333	TPL VENDOR/SUBCONTRACTOR RECOVERY 19
9334	TPL VENDOR/SUBCONTRACTOR RECOVERY 20
9335	EDS NEWBORN PAYMENT
9336	EDS HEART TRANSPLANT
9337	EDS RECOVERY CASUALTY INSURANCE
9338	EDS RECOVERY RELATIVE
9339	EDS RECOVERY ESTATE
9340	EDS RECOVERY FRAUD AND ABUSE
9341	EDS RECOVERY OTHER RECOVERIES
9342	EDS RECOVERY PART OVERPAYMENT
9343	EDS RECOVERY WRONG PROVIDER
9344	EDSRECOVERY WRONG RECIPIENT
9345	EDS RECOVERY DUPLICATE PAYMENT FULL
9346	EDS RECOVERY OTHER OVERPAYMENT
9347	DUPLICATE PAYMENT RECOVERY
9348	TPL RECOVERY ESTATE
9349	FRAUD AND ABUSE OVERPAYMENT
9350	FRAUD AND ABUSE ADMINISTRATION FINES
9351	FRAUD AND ABUSE RESTITUTION
9352	FRAUD AND ABUSE PRO DENIALS
9353	FRAUD AND ABUSE OVERPAY, ADMINISTRATION
9354	FRAUD AND ABUSE OVERPAY, RESTITUTION
9355	FRAUD AND ABUSE OVERPAY, PRO
9356	CASH CALL FOR N/H RECOUP BAL
9357	TPL BILLING CFS
9358	PSN ADMINISTRATIVE ALLOCATION
9359	EMERGENCY PAYMENT RECOUPMENT
9360	RESIDENT PROTECT T/F RECOUPMENT
9361	TPL RECOVERY OTHER RECOVERIES
9362	HMO PROCESSING FEE
9363	HMO CLAIMS AMOUNT
9364	RETRO RATE ADJUST COLLECTION
9365	BEGINNING CREDIT BALANCE
9366	ENDING CREDIT BALANCE
9367	BEGINNING DUMMY CREDIT BALANCE
9368	ENDING DUMMY CREDIT BALANCE
9369	BEGINNING RECOUPMENT BALANCE
9370	ENDING RECOUPMENT BALANCE
9371	BEGINNING DUMMY RECOUPMENT BALANCE
9372	ENDING DUMMY RECOUPMENT BALANCE
9373	DRUG UNIT DOSE ADJUSTMENT
9374	PROVIDER NUMBER WRONG FISCAL AGENT
9375	RECIPIENT NUMBER WRONG FISCAL AGENT
9376	DRUG/PROCEDURE CODE WRONG FISCAL AGENT
9377	PROCEDURE MODIFIER WRONG FISCAL AGENT
9378	UNITS OF SERVICE WRONG FISCAL AGENT
9379	SUBMITTED CHARGE WRONG FISCAL AGENT
9380	TPL PAYMENT WRONG FISCAL AGENT
9381	DUPLICATE PAYMENT FISCAL AGENT
9382	PAYMENT TO WRONG PROVIDER FISCAL AGENT
9383	MISCELLANEOUS OR UNSPECIFIED ERROR FISCAL AGENT
9384	PROVIDER NUMBER WRONG PROVIDER PROCESSING

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
9385	RECIPIENT NUMBER WRONG ? PROVIDER
9386	DRUG/PROCEDURE WRONG ? PROVIDER
9387	PROCEDURE MODIFIER WRONG ? PROVIDER
9388	UNITS OF SERVICE WRONG ? PROVIDER
9389	SUBMITTED CHARGE WRONG ? PROVIDER
9390	TPL PAYMENT WRONG ? PROVIDER
9391	DUPLICATE PAYMENT ? PROVIDER
9392	PAYMENT TO WRONG PROVIDER ? PROVIDER
9393	MISCELLANEOUS OR UNSPECIFIED ERROR
9394	PROVIDER-REQUESTED REPROCESS
9395	RECIPIENT DID NOT RECEIVE SERVICE
9396	EXTERNAL NEGATIVE BALANCE COLLECTION
9397	LIEN AMOUNT PAID TO IRS
9398	CHANGE IN RECIPIENT ELIGIBILITY
9399	RECIPIENT HAS MEDICARE COVERAGE
9400	RECIPIENT HAS VERIFIED INSURANCE COMPANY
9600	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS
9601	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND UNDER. PROVIDERS MUST SUBMIT XP-MODIFIER WHEN MEMBERS
9603	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE MEMBERS SPENDOWN MET DATE FOR THE MONTH. AN 8A FORM REQUIRED. POS PROVIDERS MUST SUBMIT THIS CLM ON PAPER.
9604	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YEARS FOR MEMBERS 19 YRS OF AGE OR OLDER.
9605	HOSPITAL LEAVE DAYS ARE LIMITED TO 15 PER HOSPITALIZATION. THE PATIENT SHOULD BE DISCHARGED AND READMITTED FOLLOWING THE HOSPITAL STAY.
9634	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS HAVE BEEN PAID FOR THE SAME PROCEDURE ON THE SAME DATE OF SERVICE
9651	SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PERCENT OF THE FLORIDA HEALTH COVERAGE PROGRAMS ALLOWED
9661	POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE
9663	ATTACHMENT BEING SENT BY PROVIDER FOR AN ELECTRONIC CLAIM
9664	THE NUMBER OF QUADRANTS BILLED ON THE CLAIM IS NOT EQUAL TO THE NUMBER OF UNITS BILLED.
9665	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES QUADRANTS
9666	THE ATTACHMENT TYPE IS NOT VALID.
9700	THE DISPENSING FEE HAS BEEN REDUCED TO THE ALLOWABLE
9701	THE QUANTITY DISPENSED HAS BEEN REDUCED TO THE ALLOWABLE QUANTITY
9702	DOLLARS ADJUSTED TO PARAMETER LIMIT
9703	QTY ADJUSTED TO PARAMETER LIMIT
9704	COVERED DAYS REDUCED TO ALLOWABLE
9705	VISITS REDUCED TO AUTHORIZED
9706	PA CHARGE REDUCED TO AUTHORIZED
9707	PA UNITS REDUCED TO AUTHORIZED
9708	THER DAYS REDUCED TO AUTHORIZED
9709	MAX 14 CONSECUTIVE THER DAYS ALLOWED
9710	HOSP LEAVE DAYS REDUCED TO AUTHORIZED
9800	CUTBACK DUE TO HMO PAYMENT/COVERAGE
9900	REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR REPLACEMENTS ARE DUE TO EXTENUATING CIRCUMSTANCE
9901	REIMBURSEMENT LIMITED TO ONE SET OF FRAMES, PER YEAR FOR MEMBERS 18 YEARS OF AGE AND YOUNGER UNLESS REPAIRS OR REPLACEMENT IS DUE TO EXTENUATING CIRCUMSTANCES
9905	SERVICE DENIED-MEDICAL NECESSITY DOCUMENTATION MUST BE PROVIDED WITH CLAIM STATING REASON FOR MEDICAL NECESSITY
9906	PRICING ADJUSTMENT - MEDICARE PART B PRICING APPLIED

EOB (Explanation of Benefits) Codes and Description

EOB Code	EOB Description
9907	TPL AMOUNT APPLIED
9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED
9909	PRICING ADJUSTMENT - 50% OF AMOUNT BILLED APPLIED
9910	PHARMACY DISPENSING FEE APPLIED
9911	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED
9912	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED
9913	PRICING ADJUSTMENT - OUTPATIENT EPOGEN PRICING APPLIED
9914	PRICING ADJUSTMENT - REVENUE CODE RATE PRICING APPLIED
9915	PRICING ADJUSTMENT - MEDICARE PART A PRICING APPLIED
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED
9917	PRICING ADJUSTMENT - PREVAILING FEE PRICING APPLIED
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9919	PRICING ADJUSTMENT - PROVIDER LOC PRICING APPLIED
9920	PRICING ADJUSTMENT - RBRVS PRICING APPLIED
9921	PRICING ADJUSTMENT - PA PRICING APPLIED
9922	PATIENT LIABILITY DEDUCTED
9923	SPENDDOWN PATIENT LIABILITY APPLIED
9924	CLAIM HAS FICA AMOUNT
9925	CLAIM HAS RECOUPMENT AMOUNT
9926	CLAIM HAS CUTBACK AMOUNT
9927	SYSTEM FUND CODE REASSIGNMENT
9929	PRICING ADJUSTMENT: PROVIDER SPECIFIC ASC PRICING APPLIED
9930	MULTIPLE SURGERY REDUCTION APPLIED
9931	PRICING ADJUSTMENT - RPICC PRICING APPLIED
9932	PER DIEM PLUS PRICING APPLIED
9933	PATIENT RESPONSIBILITY ADJUSTMENT-LTC PRICING APPLIED
9937	PRICING ADJUSTMENT - UCC FLAT FEE PRICING APPLIED
9938	PRICING ADJUSTMENT - PRICING APPLIED
9941	SERVICE PAID ACCORDING TO ANESTHESIA REIMBURSEMENT RULES FOR THE DOS
9942	PER DIEM PRICING APPLIED
9943	OUT OF STATE PRICING APPLIED
9965	TOOTH NUMBERS CANNOT BE BILLED WITH A PROCEDURE THAT REQUIRES A QUADRANT.
9991	REFUND AMOUNT LESS THAN ADJUSTED AMOUNT
9992	REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT
9995	ADJUSTMENT DETAIL MANUALLY DENIED
9996	PAYMENT REDUCED DUE TO PATIENT LIABILITY DEDUCTION
9997	PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES COLLECTED FOR THE MEMBER IN THE SAME MONTH
9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VOUCHER.
9999	PROCESSED PER MEDICAID POLICY