

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
0029	CLAIM REQUIRES DOCUMENTATION. PLEASE RESUBMIT ON PAPER. DEPENDENT ON SPECIFIC PROCEDURE CODE AND CRITERIA SET FOR REVIEW.
0030	MILEAGE RATE OR UNITS OF SERVICE MISSING OR ZEROS
0050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BILL
0056	CLAIM/DETAIL DENIED. ASSISTANT SURGEON SERVICES NOT PAYABLE FOR A VAGINAL DELIVERY.
0057	INVALID TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY
0070	TIME OF PICK UP IS MISSING OR INVALID
0096	TREATING PROVIDER NOT ELIGIBLE FOR DATE OF SERVICE
0099	INITIAL CYCLE OF CLAIM SUBMITTED BY AHCA
0102	LAST DATE OF SERVICE AFTER BILLING DATE
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).
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 EDIT DO NOTRESUBMIT.
0111	BOTH VISIT AND SURGERY NOT COVERED ON SAME DATE OF SERVICE
0118	ADMIT/DISCHARGE DATE CONFLICT
0119	INVALID NEWBORN OCCURRENCE DATE
0121	MISSING PROVIDER NUMBER
0124	INVALID DATE OF SERVICE
0127	LAST DATE OF SERVICE AFTER DATE RECEIVED
0129	PROVIDER IS NOT ELIGIBLE TO SUBMIT FEE-FOR-SERVICE CLAIMS
0132	TOTAL/SUBMITTED CHARGE MISSING
0133	SUBMITTED CHARGES/TOTAL CLAIM CHARGE CONFLICT
0136	REVENUE CENTER CODE IS MISSING/INVALID
0138	TYPE OF BILL IS INVALID
0142	CLAIM EXCEEDS 12 MONTH FILING LIMIT

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0146	HCPC/REVENUE CODE MISSING. PROCEDURE CODE MISSING.
0150	THIS PROCEDURE IS INVALID FOR THE MEMBERS SEX
0151	CLAIM DENIED. PROCEDURE/NDC/REVENUE CODE INVALID FOR DATES OF SERVICE.
0152	NDC HAS NEVER BEEN VALID
0153	PROCEDURE CODE INVALID FOR DIAGNOSIS CODE
0155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR INDIVIDUAL PROVIDER NUMBER IN BILLING FIELD
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)
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
0170	PLACE OF SERVICE IS INVALID
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
0175	FIRST SURGERY PROCEDURE CODE IS MISSING
0179	TOOTH SURFACE/QUADRANT REQUIRED
0180	INVALID ALPHA TOOTH NUMBER
0181	INVALID TOOTH SURFACE/MOUTH QUADRANT
0182	TOOTH NUMBER/LETTER REQUIRED
0184	TOTAL/SUBMITTED CHARGE MISSING
0185	ADMISSION DATE OR ACTION CODE ARE MISSING
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
0193	MISSING DATE OF SERVICE
0194	DIAGNOSIS IS INVALID FOR MEMBERS SEX

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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)
0207	A SURGICAL PROCEDURE (WITHOUT A MODIFIER) IS BILLED WITHIN THE FOLLOW-UP OF A PREVIOUS SURGICAL PROCEDURE
0212	CLAIM/DETAIL DENIED. DETAIL DIAGNOSIS INDICATOR INVALID.
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
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
0229	BILLING PROVIDER NUMBER INVALID OR NOT ON PROVIDER FILE
0230	THERAPY NOT COVERED FOR RECIPIENT 21 YEARS OF AGE OR OLDER
0235	SURGERY DATE IS BEFORE THE ADMIT DATE
0236	SURGERY DATE AFTER BILLING DATE
0242	NO LEVEL 2 PRICING RECORD FOUND FOR MODIFIERS TC OR 26
0245	SVC DATES NOT ELIGIBLE
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
0259	DATE BILLED INVALID
0260	SERVICE NOT COVERED FOR RECIPIENT PLAN
0273	RECIPIENT IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE
0274	SERVICE DATE IS AFTER THE RECIPIENTS DATE OF DEATH.
0276	SOBRA - CLAIM REQUIRES MEDICAL REVIEW
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PYMNT WAS RECEIVED BY MEMBER.
0279	CMS 1500 ALIEN CLAIM DENIED; SERVICE NOT AN EMERGENCY; NOT A COVERED BENEFIT; DO NOT RESUBMIT
0281	ABORTION PROC OR CONDITION CODE A7 OR A8 IS PRESENT AND NO ABORTION CERTIFICATE IS PRESENT

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0282	THE MEMBER HAS MEDICARE PART A PLEASE BILL MEDICARE
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B: PLEASE BILL MEDICARE
0285	RECIPIENT INELIGIBLE FOR DOS WILL PEND UP TO 14 DAYS AWAITING AHCA UPDATE. RECIPIENT ELIGIBLE RECHECKED WEEKLY FOR ARRIVAL OF AHCA UPDATE.
0296	PAY TO PROVIDER INELIGIBLE FOR DATE(S) OF SERVICE
0297	PAY TO PROVIDERS GROUP IS NOT VALID FOR THE TREATING PROVIDER
0300	TREATING PROVIDER NUMBER NOT ON FILE
0302	DPR NUMBER IS NOT FOUND ON FILE
0305	TREATING PROVIDERS CLAIM DENIED AFTER DEPT OF HEALTH AND REHAB SRVS REVIEW
0308	INVALID DATE OF SERVICE
0309	BILLING PROVIDER IS UNDER REVIEW
0312	PHYSICIANS-VALID REFERRING PROVIDER REQD FOR THIS PROC IN FIELD 17A/19. THERAPISTS, HOMEHEALTH 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
0317	UNITS BILLED ON REVENUE CODES 100-219 DO NOT MATCH COVERED DATE SPANS
0318	MANUAL PRICE-REQUIRES REPORT
0321	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE
0324	DIAGNOSIS INCOMPATIBLE WITH RECIPIENTS SEX
0332	MISSING OR INVALID AHCA ELIGIBILITY FORM FOR MEDICALLY NEEDY. PHOTOCOPIED FORM 2902 MUST CONTAIN DENIAL TCN IN TOP RIGHT WHEN RESUBMITTING
0338	FINANCIAL CLASS/PATIENT RESPONSIBILITY MISMATCH
0339	INSURANCE CODE 04 HAS BEEN SUBMITTED WITH THE CLAIM
0346	INVALID NUMBER OF DAYS COVERED
0351	ALLOW TO SUB PERCENT DIFF EX
0358	TREATING PROVIDER/REFERRING PROVIDER NUMBER ARE EQUAL

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0361	PROCEDURE CODE NOT ON FILE
0362	THE DEDUCTIBLE DOES NOT EQUAL THE MEDICARE DEDUCTIBLE, RESUBMIT WITH EOMB
0378	CLAIM DETAIL DENIED. THIS PROCEDURE CODE IS NOT COVERED.
0397	ACCOMMODATION REVENUE CODES MUST BE BILLED ON AN INPATIENT CLAIM
0400	INVALID MODIFIER FOR ARNP. REGISTERED NURSE ANESTHETISTS CAN PROVIDE ONLY ANESTHESIA SERVICES - MODIFIER 48/QK 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
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
0419	INDEPENDENT LABORATORY - INVALID PLACE OF SERVICE
0425	DATE SPAN BILLING NOT ALLOWED FOR THIS PROC CODE. BILL EACH DATE OF SERVICE ON A SEPARATE CLAIM LINE.
0439	INVALID RECIPIENT ID NUMBER
0450	MOUTH QUADRANT REQUIRED
0463	OCCURRENCE SPAN FROM DATE IS GREATER THAN THE OCCURRENCE SPAN TO DATE
0468	837D CROSSOVER DENTAL CLAIM
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.
0475	ENCOUNTER PAY TO NOT WITHIN SUBMITTER PROVIDER NETWORK
0480	PAY TO PROVIDER NOT AUTHORIZED FOR DIRECT PAYMENT. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTIONS.
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
0485	PAPER ATTACHMENT NOT RECEIVED WITHIN 21 DAYS
0492	CLAIM HAS BEEN REVIEWED. REFER TO EOB CODES 901 - 940 FOR DENIAL REASON.
0495	INVALID HOSPICE REVENUE CODE OR INVALID COMBINATION OF HOSPICE REVENUE
0506	BILLED DATE GREATER THAN BATCH DATE

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0524	MOTHER DISCHARGE DATE IS ZERO
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.
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.
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
0583	MULTIPLE ANESTHESIA PROC CODES (00100-01999) FOR THE SAME RECIPIENT, PROVIDER AND DATES OF SERVICE ARE NOT ALLOWED
0604	INVALID FINANCIAL CLASS CODE
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
0612	12TH - 24TH DIAG CODE REQUIRES MED REVIEW
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.
0633	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION
0639	CANNOT AUTO DENY ADJUSTMENT
0643	CANNOT AUTO DENY ADJUSTMENT
0647	PROVIDER NUMBER NOT ON FILE
0651	WAITING FOR PAPER ATTACHMENT FROM PROVIDER
0660	CALCULATED PAYMENT EQUALS ZERO. OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.
0661	SNU LEAVE DAYS PRESENT

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0664	PAY TO PROVIDERS MAIL IS UNDELIVERABLE. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTIONS.
0681	PAY TO PROVIDER NONPARTICIPATING
0712	PROCEDURE CODE/PROVIDER TYPE OF SERVICE CONFLICT (WAIVER PROGRAM AND CASE MANAGEMENT)
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.
0737	INVALID PROCEDURE CODE AND MODIFIER
0766	REVENUE CODE PROCEDURE CODE COMBINATION INVALID. CHARGES MOVED TO NON-COVERED
0779	INVALID PROCEDURE CODE MODIFIER
0872	FIRST DIAGNOSIS CODE NOT ON FILE
0873	SECOND DIAGNOSIS CODE NOT ON FILE
0875	THIRD DIAGNOSIS CODE NOT ON FILE
0878	FOURTH DIAGNOSIS CODE NOT ON FILE
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
0894	DETAIL DENIED. THE PRIOR AUTHORIZED AMOUNT FOR THIS PROCEDURE HAS BEEN MET.
0897	6TH THRU 11TH DIAG CODE IS NOT FOUND
0898	6TH THRU 11TH DIAG CODE IS NOT FOUND
0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
0964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 21.
0970	THIS PROCEDURE REQUIRES THE ENTRY OF A VALID ARCH CODE IN THE TOOTH NUMBER FIELD
0975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE GINGIVECTOMY PROCEDURE
1000	INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON FILE.
1001	THERAPY NOT COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE
1002	PRESCRIBER NOT ACTIVE
1003	APD GATEKEEPER ADJUSTMENT

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EOB	EOB DESCRIPTION
1011	SYSTEM ERROR
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
1033	FIRST SURGERY DATE (FIELD 74) NOT WITHIN (STATEMENT COVERS PERIOD) DATE SPAN (FIELD 6)
1034	SECOND SURGERY DATE (FIELD 81) NOT WITHIN (STATEMENT COVERS PERIOD) DATE SPAN (FIELD 6)
1035	FACILITY AND BILLING PROVIDER ID DO NOT MATCH
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
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM

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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
1070	FIRST SURGICAL PROCEDURE CODE IS INVALID
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
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/SECOND 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
1087	NPI /MEDICAID ID DOESN'T MATCH ID ON THE CLAIM
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

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1093	4TH SURGICAL PROCEDURE DATE INVALID
1094	5TH SURGICAL PROCDURE 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
1101	OCCUR SPAN FROM DATE MISSING
1102	NURSING HOME PROVIDER NOT ALLOWED TO BILL REVENUE CODES
1103	MID-MONTH RATE CHANGE
1130	OCCUR SPAN TO DATE INVALID
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
1143	KICK PAY-TO-PROVIDER AND SERV PROV ERR
1145	FIRST DIAGNOSIS CODE NOT COVERED FOR RECIPIENT PLAN
1146	SECOND DIAGNOSIS CODE NOT COVERED FOR RECIPIENT PLAN
1147	THIRD DIAGNOSIS CODE NOT COVERED FOR RECIPIENT PLAN
1148	FOURTH DIAGNOSIS CODE NOT COVERED FOR RECIPIENT PLAN
1149	FIFTH DIAGNOSIS CODE NOT COVERED FOR RECIPIENT PLAN
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

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1156	ELECTRONIC ADJUSTMENT/VOID ADJUSTING A DENIED CLAIM
1157	CLAIM NOT ON HISTORY
1158	CANNOT ADJUST A CREDIT
1159	FIRST 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
1169	SIXTH DIAGNOSIS CODE NOT COVERED
1170	FIRST SURGICAL PROCEDURE NOT COVERED FOR RECIPIENT PLAN
1171	SECOND SURGICAL PROCEDURE NOT COVERED FOR RECIPIENT PLAN
1172	THIRD SURGICAL PROCEDURE NOT COVERED FOR RECIPIENT PLAN
1173	FOURTH SURGICAL PROCEDURE NOT COVERED FOR RECIPIENT PLAN
1174	FIFTH SURGICAL PROCEDURE NOT COVERED FOR RECIPIENT PLAN
1175	SIXTH SURGICAL PROCEDURE NOT COVERED FOR RECIPIENT PLAN
1176	FIRST SURGICAL PROCEDURE NOT COVERED IN PROVIDER CONTRACT
1177	SECOND SURGICAL PROCEDURE NOT COVERED IN PROVIDER CONTRACT
1178	THIRD SURGICAL PROCEDURE NOT COVERED IN PROVIDER CONTRACT
1179	FOURTH SURGICAL PROCEDURE NOT COVERED IN PROVIDER CONTRACT
1180	FIFTH SURGICAL PROCEDURE NOT COVERED IN PROVIDER CONTRACT
1181	SIXTH SURGICAL PROCEDURE NOT COVERED IN PROVIDER CONTRACT
1182	PRIMARY DIAGNOSIS NOT COVERED IN PROVIDER CONTRACT
1183	SECOND DIAGNOSIS NOT COVERED IN PROVIDER CONTRACT
1184	THIRD DIAGNOSIS NOT COVERED IN PROVIDER CONTRACT

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1185	FOURTH DIAGNOSIS NOT COVERED IN PROVIDER CONTRACT
1186	FIFTH DIAGNOSIS NOT COVERED IN PROVIDER CONTRACT
1187	SIXTH DIAGNOSIS NOT COVERED IN PROVIDER CONTRACT
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
1203	CLAIM MUST BE PROCESSED THROUGH TELEPHONY VENDOR
1600	INVALID GROUP NUMBER
1602	TREATING PROVIDER IS A GROUP PROV
1603	PROVIDER NOT AUTHORIZED TO TAPE BILL
1908	PROCEDURE REQUIRES REVIEW OF REPORT
1914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
1937	PERFORMING PROVIDER ID NOT ON FILE
1941	OTHER PROVIDER ID NOT ON FILE
1943	INVALID DETAIL PERFORMING PROVIDER
1954	MEDICAID NUMBER INCLUDED -SUBMIT NPI ONLY
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
2001	SURGICAL PROCEDURE CONFLICTS WITH AGE LIMITATIONS
2005	NO CASH PAYMENT FOR HCBS
2006	RX-EXCEEDS DAYS SUPPLY LIMIT/REQUIRES PA
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.
2027	EXCEEDS LIMIT 1 HOME DIALYSIS SVC PER MONTH
2028	ESRD RELATED SVC LIMITED TO 1 PER DAY
2035	ESRD SERV, LIMITED TO 1 VISIT PER MO

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2036	ADDITIONAL HOURS OF TESTING REQUIRE PRIOR AUTHORIZATION
2040	THE MAMMOGRAM LIMIT HAS BEEN EXCEEDED
2042	EXCEEDS ONCE PER MONTH LIMIT
2091	RECIPIENT SERVICES COVERED BY HMO PLAN
2093	RECIPIENT IS INCARCERATED
2097	COVERED IN PER DIEM
2098	HCBW WAIVER HAS DENY/SUSPEND EDIT
2100	RECIPIENT INELIGIBLE FOR MEDICAID ONLY SERVICES
2107	NO LTC BENEFIT PLAN ON THE RECIPIENT FILE
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
2160	MISSING DIAGNOSIS INDICATOR
2168	INVALID SOURCE OF ADMISSION
2183	MISSING UNITS OF SERVICE
2199	DATE OF SURGERY IS MISSING
2200	INVALID TYPE OF ADMISSION
2202	SUB TYPE REQUIRED FOR THIS DIAGNOSIS CODE
2222	MISSING OCCURRENCE DATE
2224	INVALID OCCURRENCE DATE
2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
2239	INVALID SPAN OCCURRENCE CODE
2241	XOVER DATA MISSING AT DETAIL LEVEL
2242	MISSING OCCURRENCE CODE
2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
2249	CLAIM HAS NO DETAILS
2268	INVALID PER DIEM AMOUNT

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2277	LTC ELIGIBILITY ERROR
2289	PROCEDURE REQUIRES PRIOR AUTHORIZATION
2313	DIAGNOSIS CODE MISSING/NOT ON FILE
2314	SURGICAL PROCEDURE CODE NOT FOUND
2315	INVALID PRINCIPAL/OTHER PROCEDURE TYPE
2317	PROCEDURE CODE/MODIFIER CONFLICT
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED
2321	PROCEDURE CODE IS NO LONGER VALID
2327	PROCEDURE REQUIRES ADDITIONAL DOCUMENTATION
2345	ATTENDING PROVIDER NOT FOUND
2346	REFERRING PROVIDER NUMBER NOT ON FILE
2350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT
2352	ALLOWED TO SUBMITTED EXCEEDS PERCENT
2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID
2371	THIS DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION
2372	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY
2388	IMPROPER MODIFIER FOR CRNA
2391	INVALID USE OF E DIAGNOSIS CODE
2451	LTC INV PROVIDER NUMBER
2453	INVALID DIAGNOSIS TREATMENT INDICATOR
2462	INVALID/MISSING SPAN DATE
2463	SPAN THRU DATE LESS THAN SPAN FROM DATE
2487	PRIMARY DIAG CODE DETOX/NO DETOX REVENUE CODE
2488	ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE
2504	RECIPIENT HAS OTHER INSURANCE COVERAGE ON MEDICAID THIRD PARTY FILEPLEASE FILE WITH OTHER CARRIER OR ATTACH INSURANCE COMPANY DENIAL.
2516	PROVIDER TYPE NOT ON TPL MATRIX

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2517	TPL ON RECIPIENT FILE, NOT ON CLAIM (PAY CLAIM)
2521	TPL ON RECIPIENT FILE, NOT ON CLAIM (PAY AND LIST)
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE
2581	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN
2599	STOP LOSS THRESHOLD REACHED
2601	PART A CROSSOVER SPANS 20020501
2609	CHECK CLAIM ATTACHMENT
2615	NO PROVIDER RATE FOR DATE OF SERVICE (MAY HAVE BEEN BILLED UNDER INCORRECT PROVIDER NUMBER)
2623	THE CLAIM WAS CREATED BY A MASS ADJUSTMENT OR A MASS CREDIT
2635	FIRST OTHER PHYSICIAN ID INVALID
2664	PCS OVER 31 DAYS BILLED
2789	PROCEDURE NOT APPLICABLE FOR DIAGNOSIS SHOWN
2802	PHARMACY-POSSIBLE CONFLICT OF ANOTHER CLAIM
2857	HOSPICE TOTAL UNITS GREATER THAN TOTAL DAYS
2999	CLAIM BILLED WITH INACTIVE RID
3000	PRIOR AUTH LINE ITEM IS USED
3001	PA NOT ON FILE OR NOT IN DATE
3003	PROCEDURE CODE REQUIRES PA/REFERRAL NUM FOR DATES OF SERVICE ON OR BEFORE 20081231. PROCEDURE CODE REQUIRES PA FOR DATES OF SERVICE AFTER 20081231.
3010	PRIOR AUTHORIZATION NUMBER IS MISSING
3011	RECIPIENT WITH PARTIAL ELIGIBILITY
3012	DETAIL DATES OF SERVICE NOT WITHIN HEADER DATES OF SERVICE
3013	PART A AUTO-XOVER. REBILL PER MEDICAID POLICY
3014	DENTAL PROCEDURE LIMITED TO ONCE PER LIFETIME
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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
3046	INPATIENT SERVICES NOT APPROVED FOR ALIEN
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
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
3348	DIAGNOSIS CODE NOT COVERED FOR BIRTH CENTER PROCEDURE CODE
3358	CLAIM REQUIRES AHCA MANUAL REVIEW
3360	TAXONOMY CODE INVALID/MISSING

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
3396	UNITS OF SERVICE EXCEED MEDICALLY UNLIKELY EDIT
3601	PROCEDURE/DIAGNOSIS/DRUG NOT COVERED FOR FAMILY PLANNING
3950	MULTIPLE SERVICE LOCATIONS FOR OTHER PROVIDER 2
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM
4014	NO PRICING SEGMENT ON FILE
4016	PROCEDURE CODE INCOMPATIBLE WITH DIAG
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)
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
4061	NO REIMB RULE FOR ASSOCIATED CLAIM TYPE
4067	GENDER RESTRICTION FOR REV CODE RECIP PLAN
4068	NO REIMB RULE FOR ASSOCIATED CONTRACT
4070	INVALID PROCEDURE CODE MODIFIER
4089	MISSING OR INVALID SURGERY CODE. PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLED WITH THE SURGERY REVENUE CODE AND RESUBMIT
4108	PROVIDER CHARGE RECORD/ HMO PHP RECORD NOT FOUND
4121	MOUTH QUADRANT REQUIRED
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
4136	BILLING PT/PS RESTRICTION FOR ICD9 RECIP PLAN

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
4137	PERFORMING PT/PS RESTRICTION FOR ICD9 RECIP PLAN
4140	PAY-TO PROVIDER TYPE INVALID FOR PROCEDURE CODE
4142	BILLING PROVIDER TYPE/SPECIALTY RESTRICTION FOR REVENUE CODE
4143	TREATING PT/PS RESTRICTION FOR REV CODE-RECIP PLAN
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
4206	PROCEDURE UNITS RESTRICTION ON BILLING RULE
4218	INVALID PROCEDURE FOR CLAIM FORM
4223	PROCEDURE REQUIRES MEDICAL REVIEW
4224	BELOW MINIMUM UNIT LIMIT
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
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE
4252	DIAGNOSIS CODE 10-24 NOT ON FILE
4256	MODIFIER RESTRICTION FOR COVERED PROCEDURE
4257	INVALID PROCEDURE CODE MODIFIER
4273	3RD DIAG CODE REQUIRES AHCA REVIEW
4274	4TH DIAG CODE REQUIRES AHCA REVIEW
4275	5TH DIAG CODE REQUIRES AHCA REVIEW
4276	1ST SURG PROC REQUIRES AHCA REVIEW

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
4277	2ND SURG PROC REQUIRES AHCA REVIEW
4278	3RD SURG PROC REQUIRES AHCA REVIEW
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.
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
4362	TOB RESTRICTION FOR BILLED DIAGNOSIS
4371	CLAIM TYPE RESTRICTION FOR PROCEDURE BASED ON RECIPIENT PLAN
4393	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION
4400	REVENUE CODE REQUIRES HCPC/NDC COMBINATION
4401	HCPCS PROCEDURE REQUIRES A VALID NDC
4402	HCPCS/NDC COMBINATION NOT VALID
4403	NDC HAS BEEN TERMINATED BY CMS
4404	HCPCS/NDC NOT A REBATEABLE DRUG
4405	DESI LESS-THAN-EFFECTIVE DRUG
4415	PROCEDURE 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	REVENUE CODE/AGE CONFLICT
4760	ICD9 PROCEDURE REQUIRES MEDICAL REVIEW
4768	ICD9 PROCEDURE REQUIRES MEDICAL REVIEW

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
4776	BILLING PT/PS RESTRICTION ON DIAGNOSIS CODE
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	INVALID DIAGNOSIS FOR PROVIDER CONTRACT
4804	INVALID REVENUE CODE FOR PROVIDER CONTRACT
4806	INVALID ICD9 FOR PROVIDER CONTRACT
4810	PROVIDER CONTRACT MEDICARE CROSSOVER CLAIMS ONLY
4812	DIAGNOSIS REQUIRES MEDICAL REVIEW
4813	PROCEDURE REQUIRES MEDICAL REVIEW
4821	PROCEDURE/PLACE OF SERVICE RESTRICTION
4822	PROC CANNOT BE PERFORMED AT PLACE OF SERVICE INDICATED ON CLAIM OR IF 99160 OR 99162 BILLED. SERV PAYABLE ONLY IF EMERGENCY BLOCK CHECKED.
4831	NO REIMBURSEMENT RULE FOR SERVICES BEING BILLED
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
5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL
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
5035	PAID RELATED CLAIM
5036	NOT ALLOWED WITH C-SECTION

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
5042	NOT ALLOWED WITH OBSTETRIC PANEL
5043	NOT ALLOWED WITH OBSTETRIC PANEL-LABORATORY
5048	NOT ALLOWED WITH LIPID PANEL
5049	NOT ALLOWED WITH LIPID 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
5076	PROCEDURE CODE COMBINATION NOT ALLOWED
5077	PROCEDURE CODE COMBINATION NOT ALLOWED
5078	PROCEDURE CODE COMBINATION NOT ALLOWED

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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
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
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)

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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
5124	NOT ALLOWED WITH C-SECTION
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
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
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)

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
5149	PPEC SERVICES NOT ALLOWED SAME DAY
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
5153	MULTIPLE SURGERY PROCEDURES MUST BE BILLED ON THE SAME CLAIM. ADJUST OR VOID PAID MULTIPLE SURGERY CLAIMS FOR SAME DATE OF SERVICE/RECIPIENT AND REBILL.
5154	SERVICES NOT ALLOWED ON THE SAME DAY AS 93224
5155	SERVICES NOT ALLOWED ON THE SAME DAY AS 93230
5156	SERVICES NOT ALLOWED ON THE SAME DAY AS 93235
5157	SERVICES NOT ALLOWED ON THE SAME DAY AS UA
5158	SERVICES NOT ALLOWED ON THE SAME DAY AS VISIT
5159	SERVICES NOT ALLOWED ON THE SAME DAY AS TRANS UA
5160	SERVICE NOT ALLOWED WITH CRITICAL CARE
5161	SERVICE NOT ALLOWED SAME DATE OF SERVICE
5162	PROCEDURE CODE COMBINATION NOT ALLOWED
5163	PROCEDURE CODE COMBINATION NOT ALLOWED
5164	PROCEDURE CODE COMBINATION NOT ALLOWED
5165	PROCEDURE CODE COMBINATION NOT ALLOWED
5166	PROCEDURE CODE COMBINATION NOT ALLOWED
5167	PROCEDURE CODE COMBINATION NOT ALLOWED
5168	PROCEDURE CODE COMBINATION NOT ALLOWED
5169	PROCEDURE CODE COMBINATION NOT ALLOWED
5170	PROCEDURE CODE COMBINATION NOT ALLOWED
5171	PROCEDURE CODE COMBINATION NOT ALLOWED
5172	PROCEDURE CODE COMBINATION NOT ALLOWED
5173	PROCEDURE CODE COMBINATION NOT ALLOWED
5174	PROCEDURE CODE COMBINATION NOT ALLOWED

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
5175	PROCEDURE CODE COMBINATION NOT ALLOWED
5176	PROCEDURE CODE COMBINATION NOT ALLOWED
5177	PROCEDURE CODE COMBINATION NOT ALLOWED
5178	PROCEDURE CODE COMBINATION NOT ALLOWED
5179	PROCEDURE CODE COMBINATION NOT ALLOWED
5180	PROCEDURE CODE COMBINATION NOT ALLOWED
5181	PROCEDURE CODE COMBINATION NOT ALLOWED
5182	PROCEDURE CODE COMBINATION NOT ALLOWED
5183	NOT ALLOWED SAME DAY SAME RECIPIENT SAME PROVIDER (LABOR MANAGEMENT)
5184	NOT ALLOWED SAME DAY SAME RECIPIENT SAME PROVIDER (LABOR MANAGEMENT)
5185	NOT ALLOWED WITH SPEC OPHTHAMOL PROC
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
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	FQHC ENCOUNTER LIMIT - CANNOT BILL MULTIPLE FQHC ENCOUNTERS FOR THE SAME SERVICE DATE.
5578	FIRST DATE OF SERVICE IS BEFORE THE RECIPIENTS DATE OF BIRTH.
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	INVALID NCCI BILLING COMBINATION
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.

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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 LIMITED TO ONE PER TWO YEARS
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
6053	PROCEDURE LIMITED TO TWO PER 365 DAYS
6054	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
6055	HEARING AID DISPENSING FEES ARE LIMITED TO ONE IN THREE YEARS
6056	MAX ALLOWED 20 UNITS PER CALENDAR MONTH
6057	56 MAX UNITS OF SERVICE PER CALENDAR MONTH
6058	DAY TREATMENT NOT TO EXCEED 192 UNITS/FISCAL YEAR
6059	LEAVE DAYS EXCEEDED
6060	UNITS OF SERVICE EXCEED ALLOWED FOR THIS REVENUE CODE
6061	W1074 LIMITED TO 26 PER FISCAL YEAR FOR CMH

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
6062	MORE THAN TWO SURGEONS BILLED MODIFIER 62 FOR SAME RECIPIENT, DOS, PROCEDURE
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	SNU MAX DAYS EXCEEDEDWO 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	PROCEDURE 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
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 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	PROCEDURE LIMITED TO 1 PER 4 YEARS
6110	WALKERS LIMITED TO 1 PER 3 YEARS
6111	PROCEDURE APPLICABLE TO THIS EDIT ARE LIMITED TO 10 IN A LIFETIME
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
6115	THIS PROCEDURE IS LIMITED TO TWO TIMES IN A LIFETIME
6116	LIMITED TO 52 PER FISCAL YEAR CMH
6118	PROCEDURE 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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
6154	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6155	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6156	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6157	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6158	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
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
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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
6199	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6200	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
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
6208	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6209	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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
6227	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6228	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6229	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
6237	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6238	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
6239	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
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.
6329	HOME HEALTH VISITS LIMITED TO 60 VISITS UNLESS PRIOR AUTHORIZED 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
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

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
6348	HMO REFORM SERVICE LIMIT OF 280 DAYS FOR OB SERVICES
6350	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
6351	TREATMENT PLAN REVIEW LIMITED TO SIX TIMES PER FISCAL YEARS
6354	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
6355	BENEFIT CAP LIMIT HAS BEEN EXCEEDED DL 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
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 CALENDAR MONTH.
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.
6380	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 PER MONTH.
6381	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO LIMIT 7 UNITS PER DAY.

Explanation of Benefit (EOB) Codes and Descriptions

EOB	EOB DESCRIPTION
6382	PROCEDURE A9150 U1 LIMITED TO \$300 PER MONTH
6408	SERV LIMIT OF 2 PER LIFETIME
6554	LIMITED TO 2 PER 365 DAYS
6658	DUPLICATE DENTAL RESIN WITHIN THREE YEARS
6861	PROCEDURE INVALID IN NURSING HOME
6863	POSSIBLE DUPLICATE CONFLICT. MAY BE A CONFLICT WITH ANOTHER PROVIDERS CLAIM
7261	INVALID CHCUP REFERRAL CODE
7834	RECIPIENT SERVICES COVERED BY PMHP PLAN
8001	PROVIDER REQUESTED ADDITIONAL PAYMENT DUE TO CHANGE IN OTHER
8600	01-M/I BIN
8829	PJ-M/I INSURANCE SEGMENT
9090	DUMMY TEST CODE
9112	THIS DETAIL WAS DENIED ON THE ORIGINAL CLAIM
9666	THE ATTACHMENT TYPE IS NOT VALID.
9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VOUCHER.
9999	PROCESSED PER MEDICAID POLICY