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EOP Message Codes

Code	Message
002	PRICED PER ALLOWED AMOUNT.
003	PRICED PER ALLOWED AMOUNT.
004	THIS IS YOUR COPAY AMOUNT.
005	THIS IS YOUR COPAY AMOUNT.
006	THIS IS YOUR DEDUCTIBLE AMOUNT.
007	THIS IS YOUR DEDUCTIBLE AMOUNT.
010	THIS IS YOUR COINSURANCE AMOUNT.
011	THIS IS YOUR COINSURANCE AMOUNT.
015	PRICED PER CONTRACT OR AGREEMENT.
016	PRICED PER CONTRACT OR AGREEMENT.
017	PRICED PER CONTRACT OR AGREEMENT.
018	PRICED PER CONTRACT OR AGREEMENT.
019	PRICED PER CONTRACT OR AGREEMENT.
048	THE ALLOWABLE AMOUNT FOR THIS SERVICE WAS REDUCED ACCORDING TO AMBULATORY SURGICAL CENTER (ASC) MULTIPLE PROCEDURE GUIDELINES.
049	THE ALLOWABLE AMOUNT FOR THIS SERVICE WAS REDUCED ACCORDING TO AMBULATORY SURGICAL CENTER (ASC) DEFAULT CATEGORY GUIDELINES.
054	SERVICES WERE DENIED. ANOTHER ORGANIZATION IS PROCESSING THE CLAIM.
055	MEDICARE SUPPLEMENTAL CALCULATION APPLIED
057	FSA PAID AMOUNT OVERRIDE
059	BYPASS HRA PROCESSING
061	HRA PAID AMOUNT OVERRIDE
062	ALL FSA DOLLARS WERE PREVIOUSLY PAID OUT
065	THIS IS NOT A COVERED SERVICE UNDER YOUR FUNDING ACCOUNT
066	NOT COVERED UNDER MEDICAL PLAN - TO BE PAID AS HRA ONLY SERVICE
068	NO ANNUAL ELECTION AMT ON FILE. YOUR ANNUAL ELECTION MUST BE REPORTED BY YOUR EMPLOYER BEFORE EXPENSES MAY BE REIMBURSED FROM YOUR FSA.

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EOP Message Codes

Code	Message
069	NO ANNUAL ELECTION AMOUNT ON FILE. YOUR ANNUAL ELECTION MUST BE REPORT ED BY YOUR EMPLOYER BEFORE EXPENSES MAY BE REIMBURSED FROM YOUR FSA.
070	DEPENDENT CLAIM LINE PARTIALLY PAID
071	REIMBURSED AMOUNT LIMITED BY CONTRIBUTIONS TO-DATE. BALANCE WILL BE CONSIDERED FOR REIMBURSEMENT ONCE ADDITIONAL CONTRIBUTIONS ARE MADE.
072	ADDITIONAL NETWORX DATA
073	DENY ALL CLAIM LINES
075	AUTOMATED HRA PAYMENT BYPASSED.
100	THE MEMBER IS OLDER THAN THE PLAN'S STUDENT AGE LIMIT ALLOWS.
101	THE MEMBER IS NO LONGER ELIGIBLE BECAUSE ENROLLMENT WAS REMOVED RETROACTIVELY.
102	THE MEMBER IS NO LONGER ELIGIBLE FOR BENEFITS AFTER THE DISABILITY TERMINATION DATE.
105	COB DISALLOW
202	A REQUIRED WAITING PERIOD MUST PASS BEFORE WE CAN PROVIDE BENEFITS FOR THIS SERVICE.
205	THIS WAS PREDETERMINED UNDER THE PLAN'S MEDICAL BENEFITS.
206	WE REVIEWED THIS SERVICE FOR ACCIDENTAL INJURY BENEFITS. SINCE IT WAS THE RESTORATION THAT WAS DAMAGED, NO BENEFITS ARE AVAILABLE.
207	THIS PLAN DOESN'T HAVE SUPPLEMENTAL ACCIDENT BENEFITS THAT COVER ANY DENTAL TREATMENT.
208	WE'VE ALREADY ALLOWED BENEFITS TO RESTORE THIS TOOTH AFTER THE ACCIDENT. NO ADDITIONAL BENEFITS ARE AVAILABLE.
209	DENTAL ACCIDENT BENEFITS AREN'T AVAILABLE SINCE THE TOOTH WASN'T A SOUND NATURAL TOOTH BEFORE THE ACCIDENT.
210	OUR DENTAL CONSULTANT REVIEWED THIS TREATMENT. NO ACCIDENT BENEFITS ARE AVAILABLE.
211	DENTAL ACCIDENT BENEFITS AREN'T AVAILABLE BECAUSE IT'S BEEN MORE THAN 12 MONTHS SINCE THE ACCIDENT THAT CAUSED THE INJURY.
212	ALTERNATIVE ALLOWANCE APPLIED.
217	WE PROCESSED THE SERVICES BASED ON THE ORIGINAL DENTAL ESTIMATE.
218	THE DENTAL DEDUCTIBLE APPLIED TO THIS SERVICE.
219	THIS SERVICE IS PART OF THE PRIMARY DENTAL PROCEDURE. NO ADDITIONAL BENEFITS ARE ALLOWED.

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EOP Message Codes

Code	Message
21A	MAXIMUM BENEFITS PAID FOR THIS SERVICE
21B	THIS DIAGNOSIS IS NOT COVERED
21C	DUPLICATE OF CLAIM PROCESSED OR IN PROCESS
21D	BENEFITS NOT PROVIDED BY CONTRACT
21E	SERVICES BY A FAMILY MEMBER ARE NOT COVERED
21F	SERVICES BY THIS PROVIDER ARE NOT COVERED
21G	MAXIMUM SCHEDULED ALLOWANCE FOR THIS SERVICE
21H	ACCIDENT OCCURRED PRIOR TO EFFECTIVE DATE
21I	OTHER COVERAGE QUESTIONNAIRE NOT RETURNED.
21J	BENEFITS PROCESSED BY OTHER CARRIER
21K	MAXIMUM ALLOWANCE PAID FOR THIS SERVICE.
21L	AWAITING PRIMARY CARRIER'S EOB
21M	COVERAGE ENDED BEFORE DATE OF SERVICE.
21N	SERVICES PRIOR TO EFFECTIVE DATE
21O	OVERAGE DEPENDENT
21P	INVALID ID NUMBER
21Q	CLAIM SUBMITTED AFTER TIMELY FILING LIMIT
21R	PATIENT NOT ELIGIBLE ON DATE OF SERVICE
21S	PATIENT OVER AGE LIMIT FOR THIS SERVICE
21T	MAJOR MEDICAL LIFETIME MAXIMUM BENEFITS PAID
21U	NOT A PARTICIPATING PROVIDER
21V	MATERNITY BENEFITS FOR SUBSCRIBER OR SPOUSE
21W	ASSISTANT NOT MEDICALLY NECESSARY
21Y	ROUTINE EXAMS NOT COVERED
21Z	POSSIBLE WORKER'S COMPENSATION CLAIM
220	THE PLAN DOESN'T COVER ALLERGY-RELATED DENTAL SERVICES.

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EOP Message Codes

Code	Message
221	THE PLAN LIMITS BENEFITS FOR EXAMINATIONS, OFFICE CALLS AND CONSULTATIONS AS DESCRIBED IN THE MEMBER BENEFIT BOOKLET.
222	THE PLAN DOESN'T COVER SERVICES THAT AREN'T DENTALLY NECESSARY.
223	THE PLAN DOES NOT COVER THE REPLACEMENT OF LOST OR STOLEN NIGHTGUARDS OR PROSTHETICS.
225	PORCELAIN, CERAMIC, OR RESIN-BASED PROSTHETICS RENDERED ON 2ND AND 3RD MOLARS ARE PAYABLE AT THE ALTERNATIVE METAL ALLOWANCE.
226	THE PLAN DOESN'T COVER APPLIANCES OR RESTORATIONS NECESSARY TO ALTER THE VERTICAL DIMENSION OR RESTORE THE OCCLUSION.
227	MORE THAN ONE TREATMENT OR PROCEDURE EXISTS FOR THIS SERVICE. THIS PLAN ONLY ALLOWS FOR THE MOST COST-EFFECTIVE PROCEDURE.
228	THE ACID ETCH CHARGE SHOULD BE INCLUDED IN THE RESTORATION CHARGE. NO ADDITIONAL BENEFITS ARE ALLOWED FOR THESE SERVICES.
229	BENEFITS FOR X-RAYS TAKEN FOR ROOT CANAL THERAPY ARE INCLUDED IN THE THERAPY ALLOWANCE. NO ADDITIONAL BENEFITS ARE ALLOWED.
22A	THIRD PARTY LIABLE FOR THESE CHARGES
22B	MEDICAL INFORMATION NOT RECEIVED FROM PROVIDER
22C	ADDITIONAL INFORMATION REQUESTED FROM MEMBER
22D	INVESTIGATIVE PROCEDURES ARE NOT COVERED
22E	SERVICE NOT PAYABLE FOR THIS DIAGNOSIS
22F	SERVICES DETERMINED NOT MEDICALLY NECESSARY
22G	PRIVATE ROOM NOT MEDICALLY NECESSARY
22H	SERVICE NOT PREAUTHORIZED
22I	SERVICE NOT REFLECTED IN PROVIDED RECORDS
22J	CHARGES COMBINED TO ALLOW MAXIMUM BENEFITS
22K	SERVICE INCIDENTAL TO ALLOWED PROCEDURE
22L	PATIENT NOT ELIGIBLE ON DATE OF SERVICE
22M	HANDLE DIRECT W/VENDOR FOR LINE OF BUSINESS
22N	RESUBMIT NEW ALPHA PREFIX THROUGH LOCAL BCBS

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EOP Message Codes

Code	Message
22O	REQUIRED PREDETERMINATION HAS BEEN DENIED
22P	PAID UNDER BASIS PROGRAM BENEFITS
22Q	PRE-EXISTING CONDITIONS NOT COVERED
22R	INVALID PLACE OF TREATMENT FOR PROCEDURE
22S	INVALID PROCEDURE FOR PATIENT'S SEX TYPE.
22T	CONCURRENT MEDICAL FOR DIFFERENT PHYSICIAN
22U	OUT OF AREA NON-EMERGENCY CARE
22V	RENTAL EXCEEDS PURCHASE OR ALREADY PAID.
22W	CONDITION NOT COVERED FOR PROVIDER TYPE
22X	SERVICES RENDERED AFTER PATIENT EXPIRED
22Y	SUBSCRIBER MAY BE BALANCE BILLED
22Z	POLICYHOLDER'S PREMIUMS NOT PAID TO DATE
230	THE PLAN LIMITS BENEFITS FOR PERIODONTAL SCALING AND ROOT PLANING
231	THE PLAN DOESN'T COVER FILLINGS ON THE SAME TOOTH SURFACE MORE THAN ONCE IN A 24-MONTH PERIOD.
232	THE PLAN LIMITS COMPLETE OR FULL MOUTH SERIES X-RAYS INCLUDING PANORAMIC.
234	THE PLAN DOESN'T COVER SERVICES THAT WERE REQUIRED BECAUSE OF AN ACCIDENTAL INJURY CAUSED BY BITING OR CHEWING.
235	THE PLAN ONLY COVERS REPLACEMENT OF AMALGAM RESTORATIONS IF IT'S NEEDED DUE TO RECURRENT DECAY OR FAILURE.
236	RESIN-BASED COMPOSITE FILLINGS RENDERED ON 2ND AND 3RD MOLARS ARE PAYABLE AT THE ALTERNATIVE AMALGAM ALLOWANCE.
237	THIS ALLOWANCE WAS REDUCED BY THE AMOUNT PREVIOUSLY ALLOWED FOR SERVICES ON THIS TOOTH.
238	BENEFITS FOR TOOTH BUILDUP INCLUDING POST & CORE, ARE PROVIDED ONLY IF EXISTING CROWNS/BRIDGEWORK WERE DONE AT LEAST 5 YRS PRIOR.
239	THE PLAN DOESN'T COVER PROSTHETICS. WE PROCESSED YOUR CLAIM FOR SINGLE CROWN, INLAYS AND ONLAYS AT THE AMALGAM/COMPOSITE RATE.
23A	BENEFITS COVERED WHEN ORDERED BY PCP

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EOP Message Codes

Code	Message
23C	CLOSE OUT-REPROCESS LOCALLY AS NATIONAL
23D	BENEFITS NOT PROVIDED
23E	SERVICE IS OUT OF NETWORK
23F	CHARGES ELIGIBLE FOR MEDICARE
23G	MEDICAL VISIT SAME DAY AS SURGERY NOT COVERED
23H	SEND PHYSICAL SERVICE REPORT AND MEOB
23I	BLUE SHIELD COVERAGE ONLY
23J	BLUE CROSS COVERAGE ONLY
23K	INPATIENT BLUE CROSS COVERAGE ONLY.
23L	RESUBMIT WITH MEMBER'S PRIMARY CARE PHYSICIAN
23M	PAYMENT TO BE MADE THROUGH TRANSPLANT NETWORK
23N	HANDLE DIRECT-HOME PLAN TO PROCESS
23O	PROCESSED UNDER PRIMARY COVERAGE
23P	HOST PLAN SUBMISSION ERROR
23Q	ASO ACCOUNT NOT SUBJECT TO STATE MANDATES
23R	INCORRECT USE OF MODIFIER
23S	ADJUSTMENT TO A PREVIOUSLY SUBMITTED CLAIM
23Y	CLAIM SUBMITTED UNDER BLUECARD TRAD. PROCESSING- CLAIM SHOULD BE SUBMITTED TO POS.
23Z	CLAIM SUBMITTED AS BLUECARD POS BUT MEMBER NOT ENROLLED IN PAR PLAN NETWORK
240	PREVENTIVE & THERAPEUTIC SERVICES DONE ON THE SAME DAY ARE CONSIDERED THERAPEUTIC. WE APPLIED THE MAXIMUM BENEFIT FOR THERAPEUTIC SERVICES.
241	THIS DENTAL SERVICE IS NOT COVERED UNDER THIS PLAN.
243	RELINES, REBASES, AND ADJUSTMENTS PERFORMED WITH SIX MONTHS FOLLOWING DENTURE INSTALLATION ARE INCLUDED IN THE COST OF THE DENTURE.
244	CROWNS AND/OR COPINGS DONE IN CONJUNCTION WITH AN OVERDENTURE ARE INCLUDED IN THE OVERDENTURE ALLOWANCE.
247	THE AMOUNTS PREVIOUSLY PROVIDED FOR CROWNS AND/OR COPINGS WERE SUBTRACTED FROM THE TOTAL OVERDENTURE ALLOWANCE.

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EOP Message Codes

Code	Message
248	WE ALREADY PROCESSED THIS CHARGE AND APPLIED IT TO THE DENTAL DEDUCTIBLE.
24C	HIGH DOLLAR CLAIM-REVIEWED AND REJECTED
24D	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
24E	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER
24F	CHARGES FOR OUTPATIENT SERVICES WITH THIS PROXIMITY TO INPATIENT SERVICES NOT ALLOWED.
24G	NOT COVERED UNLESS THE PROVIDER ACCEPTS ASSIGNMENT
24H	DENIED, SERVICE/PROCEDURE PROVIDED OUTSIDE THE US OR AS A RESULT OF WAR
24I	PAYMENT ADJUSTED, TRANSPORTATION ONLY COVERED TO CLOSEST FACILITY
24J	BENEFITS ADJUSTED. PLAN PROCEDURES NOT FOLLOWED.
24K	CLAIM/SERVICE DENIED. APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET
24L	CONTRACTED FUNDING AGREEMENT-SUBSCRIBER IS EMPLOYED BY THE PROVIDER.
24M	PRIOR HOSPITALIZATION OR 30 DAY TRANSFER REQUIREMENT NOT MET.
24N	CLAIM/SERVICE NOT COVERED/REDUCED, ALTERNATIVE SERVICES AVAILABLE, NOT USED
24O	SERVICES NOT COVERED BECAUSE THE PATIENT IS ENROLLED IN A HOSPICE.
24P	PAYMENT ADJUSTED BECAUSE 'NEW PATIENT' QUALIFICATIONS WERE NOT MET.
24R	THIS IS A MEDICARE ADVANTAGE TYPE CLAIM. MEDICARE CHARGE LIMITATIONS MAY APPLY.
24S	THIS IS A BLUECARD HOST CLAIM.
24T	THIS IS A BLUECARD HOST CLAIM.
24U	THIS IS A BLUECARD HOST CLAIM.
24V	THIS IS A BLUECARD HOST CLAIM.
24W	THIS IS A BLUECARD HOST CLAIM.
24X	THIS IS A BLUECARD HOST CLAIM.
24Y	THIS IS A BLUECARD HOST CLAIM.
24Z	THIS IS A MEDICARE ADVANTAGE CLAIM; MEDICARE CHARGE LIMITATIONS MAY APPLY.
250	CAPITATED HRA SERVICE

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EOP Message Codes

Code	Message
251	THE PLAN DOESN'T COVER DENTAL IMPLANTS AND RELATED SERVICES.
252	OUR CONSULTANT REVIEWED THIS CLAIM AND NO ADDITIONAL BENEFITS CAN BE ALLOWED.
253	THE PLAN DOESN'T COVER SEALANTS ON THE SAME TOOTH MORE THAN ONCE IN A 48-MONTH PERIOD.
254	THE PLAN LIMITS COVERAGE OF PERIODONTAL ROOT PLANING AND/OR CURETTAGE IN A 24-MONTH PERIOD. NO FURTHER BENEFITS ARE ALLOWED.
255	THE PLAN COVERS THIS SERVICE OR PROCEDURE ONLY ONCE PER TOOTH PER LIFE TIME.
257	BENEFITS WERE PREDETERMINED FOR A THREE-CANAL ENDO. THE DENTAL CARE PROVIDER MUST INCLUDE A POST-OP X-RAY SHOWING FOUR CANALS.
258	OUR DENTAL CONSULTANT REVIEWED THIS CASE AND FEELS A CROWN IS NECESSARY. A TEMPORARY CROWN WAS ALLOWED DUE TO THE PATIENT'S AGE.
259	NO BENEFITS HAVE BEEN ALLOWED AT THIS TIME. PLEASE SEE THE ATTACHED LETTER.
25A	THIS IS A BLUECARD HOST CLAIM
25B	THIS IS A BLUECARD HOST CLAIM.
25C	CERTIFICATE OR LETTER OF MEDICAL NECESSITY NEEDED BEFORE CLAIM CAN BE PROCESSED.
25D	EMERGENCY SERVICES RECORDS NEEDED BEFORE CLAIM CAN BE PROCESSED.
25E	CONDITION ONSET DATE NEEDED BEFORE CLAIM CAN BE PROCESSED.
25F	PROGRESS NOTES/REPORT NEEDED BEFORE CLAIM CAN BE PROCESSED.
25G	COMPLETED SUBROGATION/WORKERS COMPENSATION QUESTIONNAIRE NEEDED FROM MEMBER BEFORE CLAIM CAN BE PROCESSED.
25H	DISCHARGE SUMMARY NEEDED BEFORE CLAIM CAN BE PROCESSED.
25I	MEDICARE PAYMENT INFORMATION NEEDED BEFORE CLAIM CAN BE PROCESSED.
25J	LABORATORY REPORT NEEDED BEFORE CLAIM CAN BE PROCESSED.
25K	OPERATIVE/SURGICAL REPORT NEEDED BEFORE CLAIM CAN BE PROCESSED.
25L	PATHOLOGY REPORT NEEDED BEFORE CLAIM CAN BE PROCESSED.
25M	RADIOLOGY REPORT NEEDED BEFORE CLAIM CAN BE PROCESSED.
25N	TREATMENT PLAN NEEDED BEFORE CLAIM CAN BE PROCESSED.
25O	THIS CLAIM INCLUDES PAYMENT FROM THE MEMBER’S PERSONAL SAVINGS ACCOUNT THIS AMOUNT INCLUDES FUNDS TO COVER MEMBER’S LIABILITY.

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EOP Message Codes

Code	Message
25Q	THESE SERVICES ARE NOT COVERED BECAUSE THEY WERE PROVIDED IN AN INPATIENT SETTING WHICH WAS DETERMINED TO BE NOT MEDICALLY NECESSARY.
25R	THESE CHARGES ARE NOT COVRD. AS A RESULT OF ARBITRATION, THESE SERVICES ARE THE RESPONSIBILITY OF THE MEMBER'S AUTO INSURANCE CARRIER
25S	PATIENT HAS NO OTHER COVERAGE; CLAIM WAS RCVD WITH OTHER CARRIER PAYMENT INFO. CHARGES WILL PROCESS WHEN INFO IS VERIFIED BY MEMBER.
25T	THESE CHARGES ARE NOT COVERED BECAUSE THE PATIENT HAS EXCEEDED THE NUMBER OF VISITS AUTHORIZED.
25U	DETAILED DESC OF SRVC IS MISSING/INVALID. INFO NEEDED TO DETERMINE MEMBER'S BENEFITS. CHARGES WILL BE CONSIDERED WHEN INFO IS RCVD.
25V	CHARGES NOT PROCESSED UNTIL WE RCV HEALTH HISTORY INFO TO DETERMINE MEMBER’S BENEFITS. CHARGES WILL BE CONSIDERED WHEN INFO IS RCVD.
25W	CHRGS DENIED UNTIL WE RCV MED HISTY INFO FROM OTHER PROV-INFO NEEDED FOR MEMBER’S BENEFITS. CHARGES WILL BE CONSIDERED WHEN INFO IS RCVD.
25X	THE MAXIMUM BENEFIT FOR SERVICES RELATING TO A PREEXISTING CONDITION HAS BEEN MET.
25Y	NO BENEFITS ARE PAYABLE FOR THIS SERVICE. THE PRIMARY CARRIER HAS PAID MORE THAN OR UP TO 100% OF THE ALLOWANCE.
25Z	CHARGES SHOWN ON CLAIM DO NOT MATCH THOSE ON THE EOMB. RESUBMIT THE CLAIM WITH CORRECTED CHARGES OR RETURN ADDITIONAL CLAIMS INFORMATION.
260	THE PLAN DOESN'T COVER THIS SERVICE BECAUSE IT'S A MEDICAL BENEFIT.
266	BENEFITS CAN'T BE ESTIMATED FOR THIS SERVICE.
267	OUR DENTAL CONSULTANT REVIEWED THIS. THE PLAN DOESN'T COVER REPLACEMENT OF AMALGAM RESTORES FOR REASONS OTHER THAN DECAY/FAILURE.
268	THIS IS A DUPLICATE OF A PREVIOUS DENTAL ESTIMATE.
26A	THIS CHARGE IS NOT COVERED. SERVICES RELATED TO EXPERIMENTAL PROCEDURES ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
26B	ROUTINE VISION IS NOT COVERED UNDER THIS CONTRACT. THESE CHARGES ARE THE MEMBER'S RESPONSIBILITY.
26C	THE SERVICES SUBMITTED EXCEED THE NUMBER OF VISITS PREVIOUSLY APPROVED.
26D	THIS CHARGE COULD NOT BE COVERED; ROUTINE PHYSICALS ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
26E	CONVENIENCE ITEMS ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.

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EOP Message Codes

Code	Message
26F	WE HAVE RECEIVED AN EOMB FROM MEDICARE. HOWEVER, WE ALSO REQUIRE AN EOB FROM THE PATIENT'S OTHER INSURANCE CARRIER.
26G	A COPY OF THE AMBULANCE REPORT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
26H	INFORMATION ABOUT THE ORDERING OR REFERRING PHYSICIAN (NAME/ADDRESS) IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
26I	A COPY OF THE PSYCHIATRIC EVALUATION, ALONG WITH THE LENGTH OF SESSION, IS NEEDED BEFORE CLAIM CAN BE CONSIDERED.
26J	HEIGHT, WEIGHT, AND FRAME OF THE PATIENT ARE NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
26K	WE DO NOT HAVE A VALID NAME AND DATE OF BIRTH FOR THIS NEWBORN.
26L	A COPY OF THE MANUFACTURER'S DESCRIPTION OF THIS SUPPLY/EQUIPMENT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
26M	ARTIFICIAL CONCEPTION AND/OR IN-VITRO FERTILIZATION SERVICES ARE EXCLUDED UNDER THE MEMBER'S BENEFIT PLAN OR POLICY.
26N	CHARGES ARE NOT COVERED. SERVICES EXCEED THE MAXIMUM NUMBER OF VISITS ALLOWED FOR HOME HEALTH CARE PER THE MEMBER'S BENEFIT PLAN OR POLICY.
26O	THIS SERVICE COULD NOT BE COVERED. THE PATIENT IS NOT WITHIN THE AGE LIMIT FOR WELL CHILD BENEFITS UNDER YOUR BENEFIT PLAN OR POLICY.
26P	PER GROUP BENEFITS, AS SECONDARY INSURER, OUR LIABILITY UNDER THIS CONTRACT IS ZERO.
26Q	WE ARE TERTIARY INS CARR. PLEASE SUBMIT CLM TO MEMBER'S PRIME AND SECOND COVRG CARRS. RESUBMIT CLM WITH BOTH EOBS TO YOUR LOCAL PLAN.
26R	BENEFITS CANNOT BE DETERMINED. WHEN GROUP RECORDS HAVE BEEN PROPERLY RECONCILED, THESE SERVICES WILL BE RECONSIDERED FOR PAYMENT.
26S	THESE SERVICES ARE NOT COVERED BECAUSE THEY WERE PROVIDED IN AN INPATIENT SETTING WHICH WAS DETERMINED TO BE NOT MEDICALLY NECESSARY.
26T	THESE CHARGES ARE NOT COVERED. TREATMENT/SERVICES OR SUPPLIES THAT DO NOT MEET HOME PLAN'S GUIDELINES ARE NOT COVD UNDER THE MEMBER'S PLAN.
26U	TRTMNT/SRVCS/SUPPLIES THAT DO NOT MEET HOME PLAN'S MED NECESSITY CRITERIA OR ARE NOT PROVIDED FOR TRTMNT OF CONDITION ARE NOT COVRD.
26V	INCIDENTAL APPENDECTOMIES PERFORMED WITHOUT EVIDENCE OF RELATED ILLNESS OR INJURY IS NOT COVERED.
26W	THESE CHARGES ARE NOT COVRD. AS A RESULT OF ARBITRATION, THESE SERVICES ARE THE RESPONSIBILITY OF THE MEMBER'S AUTO INSURANCE CARRIER

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EOP Message Codes

Code	Message
26X	THE COORDINATION OF BENEFITS INFORMATION RECEIVED IS INCOMPLETE. OTHER CARRIER PAYMENT INFORMATION IS NEEDED BEFORE CLAIM CAN BE PROCESSED.
26Y	PATIENT HAS NO OTHER COVERAGE; THIS CLAIM WAS RCVD WITH OTHER CARRIER PYMNT INFO. CHARGES WILL PROCESS WHEN INFO IS VERIFIED BY MEMBER.
26Z	THESE CHARGES ARE NOT COVERED BECAUSE THE PATIENT HAS EXCEEDED THE NUMBER OF VISITS AUTHORIZED.
270	WE'LL REVIEW THIS CLAIM FOR BENEFITS AFTER THE PROVIDER COMPLETES THE TREATMENT AND RESUBMITS THE CLAIM WITH X-RAYS AND CHART NOTES.
272	BASED ON REVIEW OF THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT HAS DETERMINED THAT THERE IS NO BENEFITS FOR THIS PROCEDURE.
273	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT HAS RE-REVIEWED THIS TREATMENT AND NO ADDITIONAL BENEFITS ARE AVAILABLE.
274	OUR PERIDONTAL CONSULTANT REVIEWED THIS CASE AND DETERMINED BENEFITS BASED ON THE NUMBER OF AFFECTED TEETH.
275	OUR RECORDS SHOW THAT THIS TOOTH WAS EXTRACTED.
276	NO BENEFITS ARE AVAILABLE SINCE THIS TOOTH IS TO BE EXTRACTED.
277	THE ALLOWED AMOUNT FOR THIS PROCEDURE WAS INCLUDED WITH THE OSSEOUS SURGERY.
278	DUE TO THE TOOTH INVOLVED, BENEFITS HAVE BEEN LIMITED TO A CAST CROWN OR ABUTMENT.
279	BENEFITS HAVE BEEN ALLOWED FOR A PARTIAL/FULL DENTURE, BUT THE PLAN HAS PROVIDED MAXIMUM BENEFITS FOR THIS BENEFIT PERIOD.
27A	THESE MATERNITY CHARGES MAY NOT BE PAYABLE AS THE MEMBER'S MAXIMUM BENEFIT HAS BEEN REACHED.
27B	THESE CHARGES ARE NOT ELIGIBLE BECAUSE THEY EXCEED THE MAXIMUM NUMBER OF UNITS AUTHORIZED.
27C	THESE CHARGES ARE NOT COVERED. THE SERVICES EXCEED THE MAXIMUM NUMBER OF VISITS ALLOWED PER THE MEMBER'S BENEFIT PLAN OR POLICY.
27D	THIS SERVICE HAS BEEN PAID AS AN EXCEPTION TO THIS PATIENT'S. CONTRACT. THIS EXCEPTION APPLIES TO THIS CLAIM ONLY.
27E	DETAILED DESC OF SRVC IS MISSING/INVALID. INFO NEEDED TO DETERMINE MEMBER'S BENEFITS. CHARGES WILL BE CONSIDERED WHEN INFO IS RCVD.
27F	CHARGES NOT PROCESSED UNTIL HOME PLAN RCVS HOSP CHARGES THAT RELATE TO SUBMITTED PROF FEE. CHARGES WILL BE CONSIDERED FOR PAYMENT.

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EOP Message Codes

Code	Message
27G	CHGS NOT PROCESSED UNTIL HOME PLAN RCVS HLTH HISTORY INFO TO DETERMINE MEMBER'S BENEFITS. CHGS WILL BE CONSIDERED WHEN INFO IS RCVD
27H	CHRGS DENIED UNTIL HOME PLAN RCVS MED HISTY INFO FROM OTHER PROV-INFO NEEDED FOR MEMBER'S BENEFITS. CHARGES WILL BE CONSD WHEN INFO IS RCVD.
27I	CHARGES DENIED TILL HOME PLAN RCVS ADD INFO. PATIENT NOT SIGNED AUTH REQD TO RELEASE INFO. CHARGES CONSID WHEN FORM AND MED RECS ARE RCVD.
27J	CHARGES CANNOT BE PROCESSED DUE TO REFERRAL FROM PATIENT'S PRMRY CARE PROV NOT RCVD. CHARGES WILL BE CONSIDERED IF A REFERRAL IS SUBMITTED.
27K	THE MAXIMUM BENEFIT FOR SERVICES RELATING TO A PREEXISTING CONDITION HAS BEEN MET.
27L	CHARGES FOR MATRNTY CARE NOT PAYABLE SINCE PATIENT NOT CONTINUOUSLY COVRD BY CONTRACT FROM DATE OF CONCEPT THRU COMPLETION OF PREGNANCY.
27M	THESE CHARGES ARE NOT COVERED. BASED UPON THE INFORMATION SUBMITTED THIS SERVICE IS COSMETIC.
27N	THESE CHARGES ARE NOT COVERED. A SURGICAL ROOM IS NOT COVERED FOR THIS TYPE OF SURGERY PERFORMED.
27O	THESE CHARGES ARE NOT COVERED. CUSTODIAL CARE IS EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
27P	CHARGES NOT COVERED. THE PRIMARY CARE PROVIDER DID NOT AUTHORIZE THE SERVICES AND THE CONDITION TREATED DID NOT MEET URGENT CARE GUIDELINES
27Q	THESE CHARGES ARE NOT COVERED. THE PATIENT'S PRIMARY PHYSICIAN HAS NOT APPROVED THIS OUT-OF-AREA CARE.
27R	THESE CHARGES ARE NOT COVERED BECAUSE THE PATIENT'S CONTRACT DOES NOT ALLOW A SECOND SURGICAL OPINION FROM THIS TYPE OF PROVIDER.
27S	THE MEDICARE PART A DEDUCTIBLE IS NOT COVERED UNDER THIS PATIENT'S PLAN.
27T	THE MEDICARE PART B DEDUCTIBLE IS NOT COVERED UNDER THIS PATIENT'S PLAN.
27U	THIS PAYMENT REPRESENTS THE GLOBAL RATE FOR THIS PATIENT'S ORGAN OR BONE MARROW TRANSPLANT.
27V	PAYMENT FOR THESE SERVICES HAS BEEN PREVIOUSLY MADE TO THE TRANSPLANT CENTER AS PART OF THE TRANSPLANT PAYMENT ALLOWANCE.
27W	THESE CHARGES ARE NOT COVERED. SERVICES RENDERED IN CONNECTION WITH DENTAL INJURY ARE INELIGIBLE UNDER YOUR PLAN.
27X	THIS SERVICE COULD NOT BE COVERED. THE MAXIMUM AMOUNT ALLOWED FOR THE FACILITY FEE FOR THIS SURGICAL PROCEDURE WAS PAID ON A PREVIOUS CLAIM.

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EOP Message Codes

Code	Message
27Y	THESE CHARGES ARE NOT COVERED. HOME HEALTH SERVICES ARE SUBJECT TO PRIOR APPROVAL UNDER THE MEMBER'S BENEFIT PLAN OR POLICY.
27Z	THE BILL TYPE SUBMITTED ON THE CLAIM IS NOT COMPATIBLE WITH THE PATIENT BILLED STATUS.
280	BENEFITS HAVE BEEN LIMITED TO AN AMALGAM OR COMPOSITE RESTORATION, BUT THE PLAN HAS PROVIDED MAXIMUM BENEFITS FOR THIS BENEFIT PERIOD.
281	THE PREVIOUS AMOUNT PAID FOR A RESTORE IS DEDUCTED FROM THIS ALLOWANCE THE PLAN HAS PROVIDED MAXIMUM BENEFITS FOR THIS BENEFIT PERIOD.
282	BENEFITS HAVE BEEN LIMITED TO AN AMALGAM OR COMPOSITE RESTORATION, BUT THE PLAN HAS ALREADY APPLIED PART OF THESE BENEFITS.
283	OUR DENTAL CONSULTANT REVIEWED THIS AND MADE AN ALTERNATIVE ALLOWANCE. THE PLAN HAS PROVIDED MAXIMUM BENEFITS FOR THIS BENEFIT PERIOD.
284	THE ALLOWED AMOUNT WAS REDUCED BY A PREVIOUSLY PAID AMOUNT FOR THIS TOOTH. THE PLAN HAS PROVIDED MAXIMUM BENEFITS FOR THIS BENEFIT PERIOD.
285	THE AMOUNT PREVIOUSLY PAID FOR THE TEMPORARY PROSTHETIC WAS DEDUCTED FROM THIS ALLOWED AMOUNT.
286	OUR PERIODONTIST HAS REVIEWED THIS CASE. BASED ON THE INFORMATION SUBMITTED, NO BENEFITS ARE AVAILABLE.
287	SERVICES IN CONJUNCTION WITH OVERDENTURES ARE LIMITED TO TWO ROOT CANAL THERAPIES AND OCCLUSAL RESTORATIONS PER ARCH.
288	THIS PLAN DOESN'T COVER NONSTANDARD TECHNIQUES USED FOR RESTORATIONS OR PROSTHETICS, SUCH AS PERSONALIZATION, PRECISION ATTACHMENTS, ETC.
289	THIS PLAN DOESN'T COVER SPECIALIZED PROCEDURES. THE ALTERNATIVE OF A NON-SPECIALIZED PROCEDURE HAS BEEN ALLOWED.
28A	NO BENEFITS ARE PAYABLE FOR THIS SERVICE. THE PRIMARY CARRIER HAS PAID MORE THAN OR UP TO 100% OF THE ALLOWANCE.
28B	A DESCRIPTION OF THE SERVICES RENDERED OR AN ITEMIZED LISTING OF CHARGES IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
28C	CHARGES SHOWN ON CLAIM DO NOT MATCH THOSE ON THE EOMB. RESUBMIT THE CLAIM WITH CORRECTED CHARGES OR RETURN ADDITIONAL CLAIMS INFORMATION.
28D	THIS CHARGE IS NOT COVERED. SERVICES RELATED TO EXPERIMENTAL PROCEDURES ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28E	COUNSELING SERVICES ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.

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EOP Message Codes

Code	Message
28F	ROUTINE VISION IS NOT COVERED UNDER THIS CONTRACT. THESE CHARGES ARE THE MEMBER'S RESPONSIBILITY.
28G	THE LINE LEVEL DATE OF SERVICE IS INVALID FOR THE HCPS/REVENUE CODE COMBINATION.
28H	OUTLIER DAYS AND ASSOC ANCILLARIES SHOULD BILL ON ONE CLAIM. APPRVD DAYS AND ANCILLARIES SHOULD BILL ON ANOTHER CLM PER MEMBER'S BENEFIT.
28I	THE SERVICES SUBMITTED EXCEED THE NUMBER OF VISITS PREVIOUSLY APPROVED
28J	WELL-BABY CARE IS EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28K	THIS CHARGE COULD NOT BE COVERED; ROUTINE PHYSICALS ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28L	HOME HEALTH CARE IS NOT COVERED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28M	ELECTROSHOCK THERAPY SERVICES ARE NOT COVERED UNDER THE BENEFIT PLAN OR POLICY.
28N	CONVENIENCE ITEMS ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28O	THIS TYPE OF DENTAL SERVICE IS EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28P	FLUORIDE TREATMENT IS NOT COVERED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28Q	CHARGES SUBMITTED DURING A LEAVE OF ABSENCE FROM THE HOSPITAL ARE NOT COVERED.
28R	HEARING EXAMINATIONS, TESTS, HEARING AIDS, AND RELATED SUPPLIES ARE EXCLUDED UNDER YOUR BENEFIT PLAN OR POLICY.
28S	THIS CHARGE COULD NOT BE COVERED, SINCE ROUTINE IMMUNIZATIONS ARE EXCLUDED UNDER YOUR BENEFIT PLAN OR POLICY.
28T	NON-COVERED ORTHOPEDIC SUPPLIES, SHOES OR ROUTINE FOOT CARE UNDER BASE AND MAJOR MEDICAL.
28U	NON-COVERED ORTHOPEDIC SUPPLIES, SHOES ARE NOT COVERED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28V	ACUPUNCTURE SERVICES ARE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
28W	BIOFEEDBACK IS EXCLUDED UNDER THE BENEFIT PLAN OR POLICY.
28X	THE PROCEDURE CODE SUBMITTED ON THIS CLAIM IS NO LONGER VALID.
28Y	HOME PLAN RECEIVED AN EOMB FROM MEDICARE. HOWEVER, IT ALSO REQUIRES AN EOB FROM THE PATIENT'S OTHER INSURANCE CARRIER.
28Z	A COPY OF THE AMBULANCE REPORT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.

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EOP Message Codes

Code	Message
290	OUR DENTAL CONSULTANT HAS RE-REVIEWED THIS CASE AND NEEDS TO REVIEW IT WHEN THE PERIODONTAL TREATMENT IS COMPLETED.
291	THIS PLAN ONLY COVERS PREVENTIVE SERVICES.
293	THIS ALLOWANCE WAS REDUCED BY THE AMOUNT PREVIOUSLY ALLOWED FOR SERVICES ON THIS TOOTH
294	THE ALLOWED AMOUNT WAS REDUCED BY THE AMOUNT PREVIOUSLY PAID FOR THIS TOOTH SINCE THE BUILDUP WAS SUBMITTED AS A FILLING.
295	BENEFITS HAVE BEEN LIMITED TO THE ALLOWED AMOUNT FOR A FULL-MOUTH SERIES OF X-RAYS.
296	THE AMOUNT PREVIOUSLY ALLOWED FOR THE AMALGAM/COMPOSITE RESTORATION HAS BEEN DEDUCTED FROM THIS PROCEDURE.
297	BENEFITS FOR SCALING AND ROOT PLANING CAN BE ALLOWED. IF SURGERY IS NEEDED, THE PROVIDER MUST RESUBMIT COMPLETE PERIO CHARTING.
298	BENEFITS WERE PREVIOUSLY ALLOWED FOR AN UPPER PARTIAL TO RESTORE THE MAXILLARY ARCH. NO ADDITIONAL BENEFITS ARE AVAILABLE FOR THIS BRIDGE.
299	BENEFITS WERE PREVIOUSLY ALLOWED FOR A LOWER PARTIAL TO RESTORE THE MANDIBULAR ARCH. NO ADDITIONAL BENEFITS ARE AVAILABLE FOR THIS BRIDGE.
29A	A COPY OF THE ANESTHESIA REPORT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
29B	HOME PLAN NEEDS THE PHYSICIAN'S OFFICE RECORDS, THE PATIENT'S HISTORY AND/OR THE PHYSICIAN'S PLAN OF TREATMENT.
29C	A COPY OF THE CURRENT BLOOD GASES REPORT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
29D	INFORMATION ABOUT THE ORDERING OR REFERRING PHYSICIAN (NAME/ADDRESS) IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
29E	A COPY OF THE PSYCHIATRIC EVALUATION, ALONG WITH THE LENGTH OF SESSION, IS NEEDED BEFORE CLAIM CAN BE CONSIDERED.
29F	THE NAME, DOSAGE, QUANTITY AND RELATED NDC NUMBER OF THIS DRUG ARE NEEDED BEFORE THIS CLAIM CAN BE CONSIDERED.
29G	HEIGHT, WEIGHT, AND FRAME OF THE PATIENT ARE BEFORE THE CLAIM CAN BE CONSIDERED.
29H	HOME PLAN DOES NOT HAVE A VALID NAME AND DATE OF BIRTH FOR THIS NEWBORN.
29I	A COPY OF THE MANUFACTURER'S DESCRIPTION OF THIS SUPPLY/EQUIPMENT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
29J	A COPY OF THE SLEEP STUDY REPORT IS NEEDED BEFORE THE CLAIM CAN BE CONSIDERED.
29K	A COPY OF THE VEIN STUDY REPORT IS NEEDED BEFORE THE CLAIM CAN BE PROCESSED.

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EOP Message Codes

Code	Message
29L	A COPY OF THE DELIVERY REPORT IS NEEDED BEFORE THE CLAIM CAN BE PROCESSED.
29M	A SEPARATE CHARGE FOR VENIPUNCTURE/ARTERIAL PUNCTURE IS NOT COVERED.
29N	ONLY THE PROFESSIONAL COMPONENT QUALIFIES FOR REIMBURSEMENT FOR THIS PROCEDURE.
29O	COVERAGE OF THIS ITEM IS ONLY CONSIDERED WHEN THE ITEM IS PURCHASED.
29P	THIS SERVICE IS PRIMARILY EDUCATIONAL AND THEREFORE EXCLUDED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
29Q	ARTIFICIAL CONCEPTION AND/OR IN-VITRO FERTILIZATION SERVICES ARE EXCLUDED UNDER THE MEMBER'S BENEFIT PLAN OR POLICY.
29R	THESE CHARGES ARE NOT COVERED. PRE-AUTHORIZATION OF HOSPICE CARE IS REQUIRED PER THE MEMBER'S BENEFIT PLAN OR POLICY.
29S	CHARGES ARE NOT COVERED. SERVICES EXCEED THE MAXIMUM NUMBER OF VISITS ALLOWED FOR HOME HEALTH CARE PER THE MEMBER'S BENEFIT PLAN OR POLICY.
29T	CHARGES ARE NOT COVERED. MAXIMUM NUMBER OF SURGICAL PROCEDURES IN A SINGLE SURGICAL SESSION HAS EXCEEDED, ACCORDING TO MEMBER'S BENEFITS.
29U	COVERAGE UNDER THE PATIENT'S BENEFIT PLAN OR POLICY IS LIMITED TO ONE MEDICAL VISIT PER DAY FOR THE SAME CONDITION.
29V	PSYCHOTHERAPY ON THE SAME DAY AS ELECTROSHOCK THERAPY IS NOT COVERED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
29W	PHARMACOLOGIC MANAGEMENT IS NOT COVERED UNDER THE PATIENT'S BENEFIT PLN OR POLICY WHEN A VISIT OR PSYCHIATRIC EXAM IS BILLED ON SAME DAY.
29X	CHARGES FOR PARTIAL UPPER OR LOWER DENTURES ARE NOT COVERED WHEN THE SAME PROVIDER HAS ALREADY BILLED FOR COMPLETE UPPER OR LOWER DENTURES.
29Y	THESE CHARGES ARE NOT COVERED. THE MAXIMUM NUMBER OF LESION SURGICAL PROCEDURES IN A SINGLE SURGICAL SESSION HAS BEEN EXCEEDED.
29Z	CHARGES NOT COVERED BECAUSE DATES ON TREATMENT PLAN DO NOT MATCH DATE(S) OF SERVICE ON THIS CLAIM. CHARGES ARE MEMBER'S RESPONSIBILITY.
30A	SVS PERFORMED UTILIZING INTERACTIVE AUDIO AND VIDEO TELECOMMUNICATION SYSTEMS NOT COVERED UNDER PATIENT'S BENEFIT PLAN OR POLICY.
30B	CHRGS NOT COV. ANESTHESIA SRVC IS COV WHEN PROV HAS RCVD APPROPRIATE CERTIFICATION. ACCORDING TO HOME PLAN, YOU HAVE NOT RCVD CERTIFICATION
30C	MODIFIER TF IDENTIFIES THIS AS AN INTERMEDIATE LEVEL OF CARE WHICH IS NOT LISTED AS A COVERED SERVICE.

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EOP Message Codes

Code	Message
30D	CHARGES NOT COV. PROC CAN ONLY BE RCVD ONCE IN A PATIENT'S LIFETIME PER MEMBER'S BENEFITS. CLAIM ALREADY PROCESSED FOR THIS TYPE OF PROC.
30E	NEWBORN HEARING TESTS ARE ONLY COVERED UNDER THE MEMBER'S BENEFIT PLAN OR POLICY WHEN SERVICES ARE RENDERED BY THE HOSPITAL.
30F	CHRG NOT COV. SPEECH THRPY COV UNDER THIS BENEFIT FOR CORRECTION OF IMPAIRMNT DUE TO DISEASE, SURG, INJURY, OR CONGENTL ANATOMICAL ANOMALY
30G	THIS SERVICE IS DENIED BECAUSE THE WAITING PERIOD FOR TRANSPLANT SERVICES HAS NOT BEEN FULFILLED.
30H	WE NEED THE FIRST CONSULTATION DATE ABOUT THIS CONDITION.
30I	HOME HEALTH CARE SVCS EXCLUDED UNDER MEMBER’S BENEFIT PLAN OR POLICY WHEN THE SVCS ARE RCVD FROM A NON-CONTRACTING HOME HEALTH CARE AGENCY.
30J	SERVICES RECEIVED IN A NON-CONTRACTING SKILLED NURSING FACILITY ARE NOT COVERED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
30K	SRVC NOT COV BECAUSE IT IS RELATED TO MATERNITY OR PREGNANCY COND. MEMBER’S BENEFITS EXCLUDE COVRG FOR MATERNITY OR PREG. RELATED COND.
30L	ROUTINE WELL BABY CARE NOT COVERED ON AN INPATIENT BASIS.
30M	THIS SERVICE COULD NOT BE COVERED. THE PATIENT IS NOT WITHIN THE AGE LIMIT FOR WELL CHILD BENEFITS UNDER YOUR BENEFIT PLAN OR POLICY.
30N	PRIVATE DUTY NURSING SERVICES ARE NOT COVERED FOR THIS PLACE OF TREATMENT.
30O	CLAIM WAS AUTOMATICALLY CROSSED OVER TO MEMBER'S PERSNL SAVINGS ACCT. YOU MAY RCV PYMNT FROM A 3RD PARTY. CHGS ARE MEMBER'S RESPONSIBILITY.
30P	THE CLAIM HAS BEEN PAID USING THE BLUE DISTINCTION CENTERS FOR TRANSPLANT NEGOTIATED RATE.
30Q	DIAGNOSIS OR SURG PROC CODE IS NOT IN EFFECT OR INCOMPLETE FOR D.O.S. PLEASE RESUBMIT WITH VALID HIPAA COMPLIANT CODE FOR DATE OF SVC.
30R	PER GROUP BENEFITS, AS SECONDARY INSURER, HOME PLAN’S LIABILITY UNDER THIS CONTRACT IS ZERO.
30S	PER MEMBER'S BENEFIT PLAN OR POLICY, SERVICES WERE DENIED BECAUSE AN AUTHORIZATION WAS APPROVED FOR AN OBSERVATION STAY ONLY.
30T	THESE CHARGES ARE NOT COVERED. THE SERVICES EXCEED THE MAXIMUM NUMBER OF UNITS ALLOWED PER THE MEMBER'S BENEFIT PLAN OR POLICY.
30U	THESE CHARGES ARE NOT ELIGIBLE BECAUSE THEY EXCEED THE MAXIMUM NUMBER OF DAYS AUTHORIZED.

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EOP Message Codes

Code	Message
30V	HOME PLN IS TERTIARY INS CARR. PLEASE SUBMIT CLM TO MEMBER'S PRIME AND SECOND COVRG CARRS. RESUBMIT CLM WITH BOTH EOBS TO LOCAL PLAN.
30W	SUBSCRIBER IS NOT HELD HARMLESS TO THESE AMOUNTS.
30X	OUR MEDICAL STAFF DETERMINED THIS PROCEDURE IS CONSIDERED COSMETIC. COSMETIC SERVICES ARE NOT COVERED BY YOUR PLAN.
30Y	CONVALESCENT OR CUSTODIAL CARE IS NOT COVERED.
30Z	THE PROVIDER NEEDS TO SUBMIT ITEMIZED CHARGES TO US.
318	WE FORWARDED THIS CLAIM TO THE MEMBER'S HOME PLAN FOR PROCESSING.
31A	THE PLAN DOESN'T COVER HEARING SERVICES.
31B	PROVIDER: PLEASE SEND US THE MEMBER'S MEDICAL RECORDS FOR THIS CLAIM. WE CAN PROCESS THE CLAIM AFTER WE RECEIVE THAT INFORMATION.
31C	PROVIDER: PLEASE SEND US MEDICAL RECORDS RELATING TO PRESCRIPTION DRUG CHARGES. WE'LL PROCESS THE CLAIM AFTER WE RECEIVE THAT INFORMATION.
31D	MATERNITY BENEFITS ARE AVAILABLE ONLY FOR THE SUBSCRIBER AND SPOUSE.
31E	THE UNITS EXCEED A CARE FACILITATION AUTHORIZATION.
31F	THIS CHARGE EXCEEDS THE MAXIMUM NUMBER OF UNITS ALLOWED FOR THIS SERVICE.
31G	SERVICE NOT COVERED SINCE ILLNESS/INJURY OCCURRED PRIOR TO EFFECTIVE DATE.
31H	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM SUBSCRIBER
320	THIS AMOUNT EXCEEDS THE MAXIMUM ALLOWABLE FOR THE SERVICE RENDERED.
32A	CHARGES ELIGIBLE FOR MEDICARE
336	ITS REFERRAL STATUS OVERRIDE
388	ITS DME AMOUNT APPLIED (SUBSCRIBER)
389	ITS DME AMOUNT APPLIED (BCBS)
401	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS ADMISSION DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.
402	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS CONTINUED STAY DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.
403	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T COVERED BY THE PLAN.

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EOP Message Codes

Code	Message
404	OUR MEDICAL STAFF DETERMINED THE MAXIMUM LIMIT HAS BEEN MET FOR THIS BENEFIT.
405	OUR MEDICAL STAFF DETERMINED PROCEDURES WHOSE EFFECTIVENESS HAS NOT YET BEEN PROVEN ARE CLASSIFIED AS INVESTIGATIVE AND ARE NOT COVERED.
406	PAYMENT OF THIS CLAIM DEPENDED ON OUR REVIEW OF INFORMATION FROM THE PROVIDER. WE HAVEN'T RECEIVED THE INFORMATION.
407	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS LEVEL OF CARE ISN'T MEDICALLY NECESSARY.
408	OUR MEDICAL STAFF REVIEWED THIS CLAIM. THE WAITING PERIOD FOR THIS SER SERVICE HASN'T PASSED YET.
409	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE SERVICE REQUESTED/PERFORMED DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.
410	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT NO ADDITIONAL REIMBURSEMENT FOR COMPLEXITY IS PAYABLE.
411	OUR MEDICAL STAFF DETERMINED THE MAXIMUM LIMIT HAS BEEN MET FOR THIS BENEFIT.
412	PAYMENT OF THIS CLAIM DEPENDED ON REVIEW OF INFORMATION FROM THE PROVIDER. THE INFORMATION WAS NOT RECEIVED.
413	OUR MEDICAL STAFF DETERMINED THAT THIS SERVICE SHOULD BE INCLUDED IN THE PRIMARY PROCEDURE.
414	OUR MEDICAL STAFF DETERMINED THAT ROUTINE MATERNITY SERVICES ARE NOT A COVERED BENEFIT.
415	OUR MEDICAL STAFF DETERMINED THIS PROCEDURE IS CONSIDERED COSMETIC. COSMETIC SERVICES ARE NOT COVERED BY YOUR PLAN.
416	OUR MEDICAL STAFF REDUCED THE ASSISTANT SURGEON'S ALLOWABLE AMOUNT.
417	OUR MEDICAL STAFF DETERMINED THAT COMPLICATIONS OF A NON-COVERED PROCEDURE ARE NOT COVERED BY YOUR CONTRACT.
418	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.
419	AFTER REVIEWING THE AVAILABLE MEDICAL RECORDS, OUR MEDICAL STAFF HAS DETERMINED THAT THIS PROCEDURE WASN'T PERFORMED.
420	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED AN ASSISTANT SURGEON WASN'T MEDICALLY NECESSARY.
422	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS CONTINUED STAY DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.

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EOP Message Codes

Code	Message
423	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE SERVICE DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.
424	THIS CLAIM CAN'T BE PROCESSED UNTIL ALL REQUIRED SIGNATURES ARE OBTAINED ON THIS PATIENT'S CARE MANAGEMENT AGREEMENT.
425	THIS CLAIM CAN'T BE PROCESSED UNTIL ALL REQUIRED SIGNATURES ARE OBTAINED ON THIS PATIENT'S CARE MANAGEMENT AGREEMENT.
426	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE /ADMIT IS NOT MEDICALLY NECESSARY.
427	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT CONTINUED STAY IS NOT MEDICALLY NECESSARY.
434	PROVIDER: THIS SERVICE'S ALLOWANCE IS INCLUDED IN ANOTHER SERVICE BASED ON YOUR APG CONTRACT.
435	THIS CHARGE EXCEEDS THE CONTRACTED AMOUNT FOR THIS SERVICE.
436	THIS CLAIM PRICED ACCORDING TO THE PROVIDER'S APG CONTRACT.
437	PROVIDER: THE ANESTHESIA TIME CHARGES FOR THIS SERVICE HAVE BEEN ADDED TO THE MAIN ANESTHESIA SERVICE.
438	PROVIDER: THE CHARGES FOR THIS SERVICE EXCEEDS THE CONTRACTED AMOUNT.
439	DISALLOWED AMOUNT, PROVIDER LIABILITY.
442	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE CRITERIA FOR THE OBESITY PROGRAM WAS NOT MET.
443	OUR MEDICAL STAFF REVIEWED AND DETERMINED THAT THE OBESITY PROGRAM WAS NOT COMPLETED.
444	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE CRITERIA FOR THE OBESITY PROGRAM WAS NOT MET.
446	THE PLAN DOESN'T COVER THE COST DIFFERENCE BETWEEN BRAND AND GENERIC DRUGS WHEN BRAND DRUGS ARE PURCHASED IN PLACE OF GENERIC DRUGS.
448	WE ARE UNABLE TO PROCESS THIS CLAIM UNTIL ADDITIONAL INCIDENT INFORMATION IS RECEIVED.
449	WORKER'S COMPENSATION IS RESPONSIBLE FOR THESE SERVICES.
450	BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE. CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
451	BENEFITS NOT PROVIDED BECAUSE AN AUTO PIP/MEDPAY POLICY IS PRIME. IF BENEFITS EXHAUST, DENY, OR STOP PAYING, PLEASE RESUBMIT TO US.

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EOP Message Codes

Code	Message
452	THE SERVICES ARE NOT COVERED BECAUSE A THIRD PARTY HAS ACKNOWLEDGED RESPONSIBILITY.
453	WE CAN'T PROCESS THIS CLAIM UNTIL THE INCIDENT QUESTIONNAIRE WE SENT THE MEMBER IS FULLY COMPLETED, SIGNED AND RETURNED.
454	WORK-RELATED ILLNESS/INJURY BENEFIT MAY BE ELIGIBLE FOR WORKERS COMPENSATION (WC). FILE WC AND CONTACT US IF BENEFITS ARE DENIED.
456	CLAIM RELATED TO CLOSED WORKER COMP CLAIM. MUST BE SUBMITTED TO WORKER COMP FOR REOPENING. IF DENIED, FORWARD DENIAL TO US FOR REVIEW.
458	BENEFITS WEREN'T PROVIDED BECAUSE THE PRESCRIPTION WAS REFILLED SOONER THAN THE PLAN ALLOWS.
459	BENEFITS WEREN'T PROVIDED BECAUSE THE PRESCRIPTION EXCEEDS THE MAXIMUM DAY SUPPLY.
462	PRESCRIPTION COPAYMENTS AREN'T ELIGIBLE FOR REIMBURSEMENT BY THE PLAN
463	THE PLAN'S ALLOWABLE AMOUNT FOR PRESCRIPTION DRUGS WAS APPLIED TO THE DEDUCTIBLE FOR PRESCRIPTION DRUGS.
464	BRAND-NAME PRESCRIPTIONS ARE REIMBURSED AT A REDUCED RATE WHEN A GENERIC SUBSTITUTE IS AVAILABLE.
465	A SECOND OPINION IS REQUIRED FOR THIS SERVICE.
470	THE MEMBER'S RESPONSIBILITY TO PAY WAS REDUCED, BASED ON OUR COORDINATION OF BENEFITS WITH THE MEMBER'S OTHER INSURANCE PLAN.
472	BENEFITS BASED ON AN ESTIMATION OF THE PRIMARY CARRIER PAYMENT. PLEASE PROVIDE PRIMARY CARRIER EXPLANATION OF BENEFITS FOR ADJUSTMENTS
473	WE NEED INFO FROM THE MEMBER'S OTHER INSURANCE CARRIER TO PROCESS THIS CLAIM. PLEASE SEND US THE OTHER CARRIER'S EXPLANATION OF BENEFITS.
475	THIS CLAIM HAS AN INVALID OR MISSING DATA ELEMENT.
476	PLEASE SUBMIT THIS CLAIM TO THE OTHER INSURANCE CARRIER. THE OTHER CARRIER IS PRIMARY.
477	BASED ON ALL SERVICES PERFORMED, WE USED A MORE MEDICALLY APPROPRIATE CODE TO ADMINISTER BENEFITS.
479	ANOTHER COVERAGE QUESTIONNAIRE WAS SENT TO THE MEMBER AND NOT RETURNED. WE PROCESSED THE CLAIM AS PRIMARY PAYER.
480	WE CANNOT PROCESS THIS CLAIM UNTIL THE OTHER COVERAGE QUESTIONNAIRE WE RECENTLY SENT THE MEMBER IS COMPLETED AND RETURNED.
483	TWO DEDUCTIBLES WERE SATISFIED BECAUSE OF TWO OTHER COVERAGES. THE SECOND DEDUCTIBLE IS BEING REIMBURSED WITH THIS CLAIM.

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EOP Message Codes

Code	Message
486	SERVICES HAVE BEEN PAID AS BILLED.
487	TO PAY THIS CLAIM, WE NEEDED TO REVIEW INFORMATION FROM THE PROVIDER. WE HAVEN'T RECEIVED THE INFORMATION.
492	MEDICARE PAID THE MAXIMUM AMOUNT ALLOWED UNDER THIS PLAN'S CARVE-OUT PROVISION.
493	THIS PLAN DOESN'T PROVIDE BENEFITS ON THE AMOUNT APPLIED TO MEDICARE'S PART B DEDUCTIBLE.
494	BENEFITS AREN'T AVAILABLE UNTIL THE MEDICARE PART A DEDUCTIBLE HAS BEEN SATISFIED.
495	THIS CLAIM WAS PAID AS A CAPITATED SERVICE.
497	THIS IS A DUPLICATE OF A PREVIOUSLY DENIED CLAIM.
498	THIS CLAIM WAS PREVIOUSLY PROCESSED TO DSHS/MEDICAID. REMAINING BALANCE IS MEMBER LIABILITY.
499	THIS LINE WAS PREVIOUSLY PROCESSED TO THE PROVIDER OR APPLIED TO THE MEMBER'S DEDUCTIBLE.
500	THIS MEMBER WASN'T ELIGIBLE FOR SERVICES ON THE DATE OF SERVICE.
502	PRUDENT LAYPERSON OVERRIDE.
503	DELEGATED CLAIM ENTITY OVERRIDE.
506	RISK INDICATOR.
507	DELEGATED UM ENTITY OVERRIDE.
509	OPT-OUT OVERRIDE.
510	SERVICE AREA OVERRIDE.
511	REIMBURSABLE ALLOWABLE AMOUNT.
525	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE OF A LOWER PARTIAL DENTURE.
528	THIS SERVICE IS PART OF THE PRIMARY DENTAL PROCEDURE. NO ADDITIONAL BENEFITS ARE ALLOWED.
529	THE MAXIMUM ALLOWABLE BENEFIT PROVIDED FOR THIS SERVICE.
530	A REQUIRED WAITING PERIOD MUST PASS BEFORE WE CAN PROVIDE BENEFITS FOR THIS SERVICE.
531	OUR RECORDS SHOW THAT THIS TOOTH WAS RECENTLY RESTORED. NO ADDITIONAL BENEFITS CAN BE ALLOWED.
532	THE PLAN LIMITS BENEFITS FOR EXAMINATIONS, OFFICE CALLS AND CONSULTATIONS AS DESCRIBED IN THE MEMBER BENEFIT BOOKLET.

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EOP Message Codes

Code	Message
533	THE PLAN DOESN'T COVER FILLINGS ON THE SAME TOOTH SURFACE MORE THAN ONCE IN A 24-MONTH PERIOD.
534	THE PLAN ALREADY PROVIDED MAXIMUM BENEFITS FOR FULL MOUTH X-RAYS, INCLUDING PANORAMIC.
536	BENEFITS WERE PREVIOUSLY ALLOWED FOR AN UPPER PARTIAL TO RESTORE THE MAXILLARY ARCH. NO ADDITIONAL BENEFITS ARE AVAILABLE.
537	BENEFITS WERE PREVIOUSLY ALLOWED FOR A LOWER PARTIAL TO RESTORE THE MANDIBULAR ARCH. NO ADDITIONAL BENEFITS ARE AVAILABLE.
538	THE FIVE-YEAR REPLACEMENT LIMITATION APPLIES IF BRIDGEWORK IS REPLACING AN EXISTING PARTIAL.
539	BENEFITS ARE ALLOWED ONLY ONCE FOR EACH SURFACE.
540	THE DENTAL PLAN DOESN'T COVER THIS DENTAL SERVICE.
541	BASED ON THE DIAGNOSIS SUBMITTED, NO BENEFITS ARE AVAILABLE.
542	THE PLAN LIMITS PROPHYLAXIS
543	THE PLAN LIMITS FLUORIDE TREATMENT.
544	THE PLAN LIMITS DENTAL BENEFITS TO AN ANNUAL MAXIMUM AMOUNT.
545	THE PLAN LIMITS BENEFITS FOR ORTHO DIAGNOSIS AND BANDING.
546	THE PLAN LIMITS LIFETIME BENEFITS FOR ORTHODONTIC SERVICES.
547	THE PLAN DOESN'T COVER IMPLANTS CROWNS. AN ALTERNATIVE ALLOWANCE FOR A COVERED CROWN APPLIED
548	THE MEMBER'S AGE EXCEEDED THE PLAN'S AGE LIMIT FOR THIS TREATMENT.
550	THIS MEMBER WASN'T ELIGIBLE FOR SERVICES ON THE DATE OF SERVICE.
551	OUR MEDICAL STAFF DETERMINED THE MAXIMUM LIMIT HAS BEEN MET FOR THIS BENEFIT.
554	WE APPLIED ALL OR PART OF THE NON-COVERED AMOUNT TOWARD THE MEMBER'S CO-INSURANCE, COPAYMENT OR DEDUCTIBLE.
555	THE MEMBER HAS REACHED THE COPAYMENT LIMIT.
556	THE MEMBER HAS SATISFIED THE DEDUCTIBLE.
557	THE CHARGES CREDITED TO THE DEDUCTIBLE DURING THE CARRY-OVER PERIOD HAVE BEEN INCLUDED IN THE TOTAL DEDUCTIBLE CREDITED ON THIS CLAIM.
558	WE ALREADY PAID THE MAXIMUM BENEFITS FOR HEARING AIDS.

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EOP Message Codes

Code	Message
559	THE PLAN ONLY COVERS A HEARING EXAM WITH THE PURCHASE OR RENTAL OF A HEARING AID.
560	THE PLAN DOESN'T COVER HEARING SERVICES.
561	THE MEMBER HAS RECEIVED THE PLAN'S LIFETIME MAXIMUM BENEFITS.
562	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED FOR THIS VISIT, BENEFIT PERIOD OR CALENDAR YEAR.
563	THE MEMBER HAS RECEIVED THE MAXIMUM BENEFITS FOR THIS MATERNITY SERVICE.
564	OUR MEDICAL STAFF DETERMINED THAT ROUTINE MATERNITY SERVICES ARE NOT A COVERED BENEFIT.
565	MATERNITY BENEFITS ARE AVAILABLE ONLY FOR THE SUBSCRIBER AND SPOUSE.
567	THE PLAN HAS PROVIDED BENEFITS FOR THE MAXIMUM NUMBER OF DAYS IN A SKILLED NURSING FACILITY.
568	THE PLAN'S "RECENT TREATMENT" PROVISION DOESN'T PROVIDE BENEFITS FOR THIS SERVICE.
569	THIS MATERNITY PLAN WAS ADJUSTED TO REFLECT THE COMPLEXITY OF THE OB CARE.
573	THE PLAN COVERS CONTACT LENSES AT THE SINGLE-VISION LENS ALLOWABLE AMOUNT.
574	THE PLAN COVERS CONTACT LENSES AT THE ALLOWABLE AMOUNT FOR SINGLE- VISION LENS PLUS THE ALLOWABLE AMOUNT FOR FRAMES.
575	OUR MEDICAL STAFF DETERMINED THIS PROCEDURE IS CONSIDERED COSMETIC. COSMETIC SERVICES ARE NOT COVERED BY YOUR PLAN.
576	THE PLAN DOESN'T COVER THIS SERVICE WHEN IT'S BILLED WITH THIS DIAGNOSIS.
577	THIS SERVICE IS CONSIDERED INVESTIGATIONAL/EXPERIMENTAL. THE PLAN DOESN'T COVER INVESTIGATIONAL/EXPERIMENTAL SERVICES.
578	THE PLAN DOESN'T COVER THIS SERVICE.
579	MAXIMUM BENEFITS HAVE BEEN PROVIDED FOR THIS CALENDAR YEAR.
580	THE PROVIDER OF THIS SERVICE IS OUT-OF-NETWORK. AN IN-NETWORK PROVIDER MUST BE USED FOR COVERAGE.
581	THIS SERVICE IS CONSIDERED A STANDARD EXCLUSION.
582	THE PLAN DOESN'T COVER THIS SERVICE.
583	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.
585	REFUND DUE TO WRONG SUBSCRIBER CONTRACT BENEFIT APPLIED.

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EOP Message Codes

Code	Message
586	REFUND DUE TO COORDINATION OF BENEFITS WITH OTHER CARRIER.
587	REFUND RECEIVED FOR DUPLICATE PAYMENT ON A CLAIM.
588	REFUND RECEIVED FOR WORK RELATED ILLNESS OR INJURY.
589	REFUND RECEIVED ON THESE ACCIDENT RELATED CHARGES BECAUSE A THIRD PARTY HAS ACKNOWLEDGED THEIR RESPONSIBILITY FOR THIS ACCIDENT.
590	REFUND RECEIVED BECAUSE A PERSONAL INJURY PROTECTION OR MEDICAL PAYMENT POLICY IS LIABLE.
595	SERVICES DENIED DUE TO PRE-EXISTING CONDITIONS WAITING PERIOD.
596	PROVIDER: THIS SERVICE FALLS OUTSIDE THE RANGE OF CODES COVERED BY YOUR CONTRACT.
597	THIS PLAN DOESN'T COVER THIS SERVICE.
599	THIS SERVICE IS INCLUDED IN THE PROVIDER'S BLUE DISTINCTION CENTERS FOR TRANSPLANT (BDCT) GLOBAL CASE RATE.
600	BENEFITS WERE PREVIOUSLY ALLOWED FOR AN UPPER PARTIAL TO RESTORE THE MAXILLARY ARCH. NO ADDITIONAL BENEFITS ARE AVAILABLE.
601	BENEFITS WERE PREVIOUSLY ALLOWED FOR A LOWER PARTIAL TO RESTORE THE MANDIBULAR ARCH. NO ADDITIONAL BENEFITS ARE AVAILABLE.
602	OUR DENTAL CONSULTANT CAN'T DETERMINE BENEFITS AVAILABLE UNTIL WE REVIEW THE INFORMATION WE REQUESTED.
603	THE FIVE-YEAR REPLACEMENT LIMITATION APPLIES IF BRIDGEWORK IS REPLACING AN EXISTING PARTIAL.
604	BENEFITS ARE ALLOWED ONLY ONCE FOR EACH SURFACE.
605	THE DENTAL PLAN DOESN'T COVER THIS DENTAL SERVICE.
606	BASED ON THE DIAGNOSIS SUBMITTED, NO BENEFITS ARE AVAILABLE.
607	OUR DENTAL CONSULTANT HAS REQUESTED THE FIVE YEAR PROGNOSIS OF THIS TOOTH.
608	PLEASE INDICATE THE ACTUAL TIME OF IV SEDATION OR GEN ANESTHESIA WHEN SUBMITTING FOR PAYMENT. DENTAL ESTIMATE IS BASED ON THE FIRST 30 MINS
609	PLEASE RESUBMIT WITH ADA CODES OR A COMPLETE DESCRIPTION OF THE SERVICE.
610	ON THE X-RAY(S) SUBMITTED, THIS TOOTH APPEARS TO HAVE A CROWN. PLEASE RESUBMIT WITH AGE OF THE CROWN OR A NARRATIVE DESCRIBING THE TOOTH.
611	OUR DENTAL CONSULTANT HAS REQUESTED CHART NOTES OR OFFICE RECORDS TO REVIEW THIS CASE.
612	OUR DENTAL CONSULTANT CAN'T MAKE A DECISION BASED ON THE X-RAY(S) SUBMITTED AND HAS

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EOP Message Codes

Code	Message
	REQUESTED A CLEARER FILM/STUDY MODELS, IF AVAILABLE.
613	OUR DENTAL CONSULTANT HAS REQUESTED A CLEARER X-RAY(S) AND A NARRATIVE.
614	OUR DENTAL CONSULTANT HAS REQUESTED A CLEARER X-RAY(S) TO REVIEW THIS CASE. PLEASE LABEL X-RAYS LEFT AND RIGHT.
615	OUR PERIODONTIST HAS REQUESTED COMPLETE AND CURRENT PERIODONTAL CHARTING BEFORE MAKING A DETERMINATION.
616	OUR DENTAL CONSULTANT HAS REQUESTED COMPLETE PERIODONTAL CHARTING, CASE TYPE, PROGNOSIS AND X-RAY(S).
617	THE SUBMITTED X-RAY(S) DOES NOT MATCH THE NARRATIVE. PLEASE CLARIFY AND RESUBMIT WITH THE CORRECT X-RAY(S) AND/OR NARRATIVE.
618	THE SUBMITTED PHOTOGRAPH AND X-RAY(S) DOES NOT MATCH. PLEASE CLARIFY AND RESUBMIT WITH CORRECT PHOTO AND X-RAY(S).
619	OUR PERIODONTIST HAS REQUESTED CURRENT PERIODONTAL PROBINGS, FULL-MOUTH X-RAY(S) AND COMPLETE OCCLUSAL FINDINGS IF AVAILABLE.
620	PLEASE RESUBMIT CURRENT X-RAY(S) AND PERIODONTAL CHARTING.
621	PLEASE RESUBMIT WITH THE DATE THAT THE ENDODONTIC THERAPY WAS COMPLETED ON THIS TOOTH.
622	OUR CONSULTANT HAS REQUESTED THE DATE THE PREVIOUS ROOT CANAL WAS DONE AND THE REASON IT NEEDS TO BE RETREATED.
623	PLEASE RESUBMIT THE DATE THIS TOOTH WAS EXTRACTED.
624	THIS TREATMENT CAN BE REVIEWED FOR BENEFITS WITH THE EXACT DATE OF PRIOR PLACEMENT.
625	PLEASE RESUBMIT WITH DOCUMENTATION SHOWING THE HISTORY OF THE PATIENT'S ACTIVE PERIODONTAL THERAPY.
627	OUR PERIODONTIST REQUESTS NECESSITY FOR SURGERY.
628	OUR PERIODONTIST REQUESTS NECESSITY FOR SURGERY AND AN X-RAY IF AVAILABLE.
629	PLEASE RESUBMIT WITH FULL MOUTH X-RAYS AND THE COMPLETE TREATMENT PLAN.
630	IS THIS INITIAL PLACEMENT? IF NOT, PLEASE PROVIDE THE AGE OF THE EXISTING PROSTHESIS.
631	PLEASE LABEL THE X-RAY(S) WITH LEFT AND RIGHT.
633	OUR DENTAL CONSULTANT REQUESTS A MORE CURRENT X-RAY TO REVIEW THIS TREATMENT PLAN.
634	OUR PERIODONTIST REQUESTS LEGIBLE PERIODONTAL CHARTING TO DETERMINE AVAILABLE BENEFITS.

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EOP Message Codes

Code	Message
635	OUR DENTAL CONSULTANT IS CONCERNED ABOUT THE FIVE-YEAR PROGNOSIS ON THIS TOOTH. PLEASE RESUBMIT WITH A NARRATIVE AND X-RAY(S).
636	OUR DENTAL CONSULTANT HAS REVIEWED THIS CASE AND HAS REQUESTED A NARRATIVE DESCRIBING WHICH CUSPS/AREAS OF THE TOOTH HAVE FRACTURED.
637	OUR PERIODONTIST HAS REVIEWED THIS CASE AND IS REQUESTING A NARRATIVE SINCE IT'S NOT CLEAR WHY THE GRAFTS ARE NECESSARY.
638	BASED ON THE X-RAYS THE EXISTING RESTORATION(S) DOES NOT APPEAR NECESSARY TO REPLACE. PLEASE RESUBMIT NARRATIVE DESCRIBING NECESSITY.
639	WE CAN'T PROCESS THIS CLAIM WITHOUT THE NECESSARY DENTAL INFORMATION FROM THE PROVIDER.
640	OUR DENTAL CONSULTANT REQUESTS NECESSITY FOR EXTRACTION.
641	OUR DENTAL CONSULTANT HAS REQUESTED AN X-RAY(S), THE DATE THE PREVIOUS ROOT CANAL WAS DONE AND THE REASON THE ROOT CANAL NEEDS TO BE REDONE.
642	PLEASE RESUBMIT WITH A PANORAMIC FILM.
643	OUR CONSULTANT HAS REQUESTED PERIAPICAL X-RAY(S) OF THE AFFECTED AREA.
644	PLEASE RESUBMIT WITH PERIODONTAL CHARTING.
645	PLEASE RESUBMIT WITH PERIODONTAL CHARTING THAT SHOWS THE OCCLUSAL FINDINGS.
646	PLEASE RESUBMIT WITH THE PERIODONTAL CHARTING, FIVE-YEAR PROGNOSIS, X-RAY(S) AND ALL MISSING TEETH IN THE ARCH.
648	PLEASE RESUBMIT WITH PERIODONTAL CHARTING, TYPE OF MATERIAL TO BE USED AND A NARRATIVE OF THE PATIENT'S PRIOR ACTIVE PERIODONTAL TREATMENT.
649	OUR DENTAL CONSULTANT HAS REVIEWED THIS CASE AND NEEDS PERIODONTAL CHARTING, PERIODONTAL STATUS AND FIVE-YEAR PROGNOSIS.
650	OUR PERIODONTAL CONSULTANT NEEDS PERIODONTAL CHARTING, INCLUDING THE TISSUE DEFECTS TO DETERMINE THE AVAILABLE BENEFITS.
651	OUR DENTAL CONSULTANT NEEDS A PHOTO OF THIS TOOTH TO DETERMINE AVAILABLE BENEFITS.
652	INSUFFICIENT NEW INFORMATION TO CHANGE PREVIOUS DECISION OR BENEFIT.
653	PLEASE FURNISH PREP/IMPRESSION AND SEAT/DELIVERY DATES WHEN SUBMITTING FOR PAYMENT.
654	OUR PERIODONTIST NEEDS THE RECESSION AND THE AMOUNT OF GINGIVA DOCUMENTED TO DETERMINE AVAILABLE BENEFITS.
655	PLEASE RESUBMIT WITH THE AGE OF THE EXISTING PARTIAL.

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EOP Message Codes

Code	Message
656	PLEASE RESUBMIT WITH THE CORRECT X-RAY.
658	PLEASE RESUBMIT WITH FULL-MOUTH X-RAYS.
659	PLEASE RESUBMIT WITH THE ITEMIZED CHARGES.
660	PLEASE RESUBMIT WITH THE TOOTH NUMBER OR AREA INVOLVED.
661	PLEASE RESUBMIT WITH VALID ADA CODE.
662	THERE'S CONCERN ABOUT THE PROGNOSIS OF THIS BRIDGE. PLEASE RESUBMIT WITH X-RAYS AND A DETAILED NARRATIVE ON THE FIVE-YEAR PROGNOSIS.
663	PLEASE RESUBMIT WITH SPECIFIC TEETH NUMBERS AND AN X-RAY OF THE SITE.
664	PLEASE INDICATE SPECIFIC TOOTH OR TEETH FOR THIS PROCEDURE.
665	OUR DENTAL CONSULTANT HAS REQUESTED STUDY MODELS, IF AVAILABLE, TO DETERMINE AVAILABLE BENEFITS.
666	OUR DENTAL CONSULTANT RE-REVIEWED THIS CASE. THE X-RAY(S) SUBMITTED DOES NOT SHOW NECESSITY FOR CROWNS. RESUBMIT STUDY MODELS OR PHOTOS.
667	OUR DENTAL CONSULTANT HAS REVIEWED THIS CASE AND WILL NEED STUDY MODELS OR A PHOTOGRAPH TO DETERMINE AVAILABLE BENEFITS.
669	PLEASE RESUBMIT WITH NARRATIVE DESCRIBING THE EXISTING RESTORATION(S) AND THE AREAS OF NEW DECAY AND/OR BREAKDOWN.
670	PLEASE RESUBMIT WITH THE TYPE AND PURPOSE OF THE APPLIANCE.
674	PLEASE RESUBMIT WITH X-RAY(S).
675	PLEASE RESUBMIT WITH X-RAY(S) AND ALL MISSING TEETH IN THE ARCH.
676	PLEASE RESUBMIT WITH X-RAY(S) AND PERIO CHARTING.
677	OUR DENTAL CONSULTANT HAS REQUESTED X-RAY(S) TO REVIEW THIS TREATMENT PLAN.
678	PLEASE RESUBMIT WITH X-RAY(S), PERIODONTAL CHARTING, FIVE-YEAR PROGNOSIS AND REASON FOR REPLACEMENT.
679	PLEASE RESUBMIT WITH X-RAY(S), NARRATIVE AND RATIONALE FOR THE PROPOSED SURGERY.
680	OUR CONSULTANT REVIEWED THIS CASE AND HAS REQUESTED X-RAYS AND A NARRATIVE REGARDING THIS TREATMENT.
681	PLEASE RESUBMIT X-RAY(S), NARRATIVE AND EXPLAIN IF THIS IS AN INITIAL PLACEMENT OR PROVIDE THE DATE OF PRIOR PLACEMENT.

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EOP Message Codes

Code	Message
682	PLEASE SUBMIT X-RAY(S) IF AVAILABLE. IF X-RAY(S) IS NOT AVAILABLE, SUBMIT STUDY MODELS OR A PHOTOGRAPH.
683	OUR PERIODONTIST HAS REQUESTED CURRENT PROBINGS, INCLUDING MOBILITY ESTIMATES AND FIVE-YEAR PROGNOSIS FOR EACH TOOTH.
684	PLEASE RESUBMIT WITH MEDICAL NECESSITY FOR GENERAL ANESTHESIA.
685	PLEASE RESUBMIT WITH A NARRATIVE AND RATIONALE FOR THE PROPOSED TREATMENT.
687	OUR DENTAL CONSULTANT HAS REQEUSTED X-RAY(S) OF THE ARCH AND THE PROGNOSIS OF THE TEETH INVOLVED.
688	PLEASE RESUBMIT WITH X-RAY(S), ALL MISSING TEETH, AND EXPLAIN IF THIS IS INITIAL PLACEMENT OR PROVIDE THE DATE OF PRIOR PLACEMENT.
689	THE PLAN LIMITS PROPHYLAXIS.
690	THE PLAN LIMITS FLUORIDE TREATMENT.
691	THE PLAN LIMITS DENTAL BENEFITS TO AN ANNUAL MAXIMUM AMOUNT.
692	THE PLAN LIMITS BENEFITS FOR ORTHO DIAGNOSIS AND BANDING.
693	THE PLAN LIMITS LIFETIME BENEFITS FOR ORTHODONTIC SERVICES.
694	THE PROCEDURE WAS PRICED TO THE AMALGAM ALLOWED AMOUNT.
695	THE MEMBER'S AGE EXCEEDED THE PLAN'S AGE LIMIT FOR THIS TREATMENT.
696	THE PLAN DOESN'T COVER THIS PROCEDURE BECAUSE IT WAS PERFORMED ON A PREVIOUSLY EXTRACTED TOOTH.
697	PLEASE RESUBMIT WITH THE DATE THAT THE ORTHODONTIC TREATMENT STARTED.
698	BASED ON THE INFORMATION SUBMITTED OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE FILLING ALLOWANCE.
699	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE OF A UPPER PARTIAL DENTURE.
700	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
701	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
702	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
706	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
707	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.

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EOP Message Codes

Code	Message
708	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
709	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
710	THIS CLAIM WAS PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
741	THE CHARGES FOR THIS SERVICE HAVE BEEN COMBINED INTO THE PRIMARY PROCEDURE BASED ON THE PROVIDERS CONTRACT.
750	THE PAYMENT WAS REDUCED FROM THE PRIVATE ROOM RATE TO THE SEMI-PRIVATE ROOM RATE.
751	OUR MEDICAL STAFF REDUCED THE ASSISTANT SURGEON'S ALLOWABLE.
753	HOME MEDICAL EQUIPMENT RENTAL CAN'T EXCEED THE PURCHASE PRICE. WE DEDUCTED THE PREVIOUSLY PAID RENTAL AMOUNT.
759	THIS CHARGE EXCEEDS THE CONTRACTED AMOUNT FOR THIS SERVICE.
760	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
761	THE CHARGE FOR THIS SERVICE ISN'T AN ALLOWED CHARGE.
763	THESE CHARGES ARE INCLUDED IN THE MAIN ANESTHESIA SERVICE.
767	THIS CLAIM IS BEING DISALLOWED AS A COSMETIC PROCEDURE.
768	THIS SERVICE IS BEING DISALLOWED AS AN INVESTIGATIONAL OR EXPERIMENTAL PROCEDURE.
769	THIS SERVICE IS BEING DISALLOWED AS A NON COVERED SERVICE.
770	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED.
773	THIS CHARGE EXCEEDS THE CONTRACTED AMOUNT FOR THIS SERVICE.
774	PROVIDER: PLEASE RESUBMIT THIS CLAIM WITH A VALID DIAGNOSIS CODE.
775	PROVIDER: PLEASE SUBMIT MANUFACTURED SUGGESTED RETAIL PRICE INVOICE. THIS CLAIM WILL BE PROCESSED AFTER WE RECEIVE IT.
776	THIS CLAIM PRICED ACCORDING TO THE PROVIDER'S APG CONTRACT.
778	THIS SERVICE HAS BEEN PACKAGED BY APG GROUPER.
780	PROVIDER: THIS SERVICE HAS BEEN CONSOLIDATED DUE TO APG PRICING.
782	PROVIDER: PLEASE RESUBMIT WITH A CPT/HCPCS PROCEDURE FOR THE SERVICE PERFORMED.
802	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T COVERED UNDER THE TERMS OF THE PLAN.

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EOP Message Codes

Code	Message
803	OUR MEDICAL STAFF DETERMINED THAT COMPLICATIONS OF A NON-COVERED PROCEDURE ARE NOT COVERED BY YOUR CONTRACT.
804	THE PLAN DOESN'T COVER SERVICES RELATED TO A CONTRACT EXCLUSION.
805	OUR MEDICAL STAFF DETERMINED PROCEDURES WHOSE EFFECTIVENESS HAS NOT YET BEEN PROVEN ARE CLASSIFIED AS INVESTIGATIVE AND ARE NOT COVERED.
806	BENEFITS AREN'T AVAILABLE FOR ANY SERVICE OR SUPPLY THAT HASN'T BEEN CHARGED/BILLED.
808	THE PLAN DOESN'T COVER SERVICES PERFORMED BY A FAMILY MEMBER.
809	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T MEDICALLY NECESSARY.
811	BASED ON THE OFFICE RECORDS, A MORE APPROPRIATE CODE WAS USED TO ADMINISTER BENEFITS.
813	OUR MEDICAL STAFF DETERMINED THAT THIS SERVICE DOESN'T MEET THE CRITERIA FOR MEDICAL NECESSITY.
814	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE IS INCIDENTAL TO A NON-COVERED PROCEDURE.
815	OUR MEDICAL STAFF DETERMINED THAT THIS SERVICE SHOULD BE INCLUDED IN THE PRIMARY PROCEDURE.
816	AFTER REVIEWING AVAILABLE MEDICAL RECORD, OUR MEDICAL STAFF DETERMINED THAT THIS PROCEDURE WASN'T PERFORMED BY THE BILLING PROVIDER.
817	AFTER REVIEWING THE AVAILABLE MEDICAL RECORDS, OUR MEDICAL STAFF DETERMINED THAT THIS PROCEDURE WASN'T PERFORMED.
819	THE MEMBER ISN'T ELIGIBLE FOR THE DATE OF SERVICE. BUT WE ARE PAYING THE CLAIM BECAUSE OUR MANAGEMENT TEAM ISSUED A PREAUTHORIZATION.
820	THE ALLOWABLE AMOUNT FOR THIS SERVICE HAS BEEN REDUCED TO DSHS PAID AMOUNT.
821	THE CONTRACT PRICING FOR THE SERVICE PROVIDER WAS USED TO PAY DSHS.
822	WE HAVE PREVIOUSLY PAID DSHS FOR THIS SERVICE/CLAIM.
823	THIS CLAIM IS A DUPLICATE OF THE SERVICING PROVIDER'S PREVIOUSLY SUBMITTED CLAIM THAT WAS EITHER PAID OR APPLIED TO THE DEDUCTIBLE.
824	THIS CLAIM IS A DUPLICATE OF THE SERVICING PROVIDER'S PREVIOUSLY SUBMITTED CLAIM THAT WAS DENIED.
825	ADJUSTED TO MEDICARE ALLOWED AMOUNT

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EOP Message Codes

Code	Message
826	OUR MEDICAL STAFF DETERMINED THAT THIS CONTINUED STAY IS NOT MEDICALLY NECESSARY.
827	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE LEVEL OF CARE ISN'T MEDICALLY NECESSARY.
828	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE WAITING PERIOD HASN'T PASSED YET.
829	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT NO ADDITIONAL REIMBURSEMENT FOR COMPLEXITY IS PAYABLE.
830	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THE SERVICE REQUESTED/PERFORMED DOESN'T MEET OUR CRITERIA.
831	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND FOUND THAT THIS PROCEDURE DOESN'T NORMALLY REQUIRE THE SERVICES OF AN ASSISTANT SURGEON.
835	THE MEMBER IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN BILLED CHARGES AND ALLOWED CHARGES WHEN THE SERVICE PROVIDER IS OUT-OF-NETWORK.
836	THE MAXIMUM BENEFITS/COPAYMENTS FOR THIS SERVICE HAVE BEEN PROVIDED FOR THIS VISIT, BENEFIT PERIOD, OR CALENDAR YEAR.
837	THIS CLAIM WAS COORDINATED WITH YOUR OTHER COVERAGE.
838	THIS CLAIM WAS PROCESSED UNDER YOUR PRIMARY COVERAGE AND WILL BE PROCESSED UNDER YOUR SECONDARY COVERAGE.
840	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
841	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
843	THE PROVIDER ISN'T ELIGIBLE TO PERFORM THE PROCEDURE(S) BILLED.
846	PROVIDER: PLEASE SEND US YOUR OPERATIVE NOTES FOR THIS CLAIM. WE CAN PROCESS THE CLAIM AFTER WE RECEIVE THAT INFORMATION.
850	THE PAYMENT WAS REDUCED DUE TO A BALANCE OWED BY PROVIDER.
852	BENEFITS FOR THIS SERVICE WERE PAID AS AN EXCEPTION TO THE MEMBER'S CONTRACT BENEFIT BASED ON AN AUTHORIZATION BY OUR PROFESSIONAL STAFF
867	THE PROVIDER PAYMENT HAS BEEN REDUCED TO OFFSET A PREVIOUS ADVANCEMENT OF PAYMENT.
868	YOUR PAYMENT HAS BEEN REDUCED TO CORRECT YOUR CAPITATION SETTLEMENT.
869	YOUR FEE-FOR-SERVICE PAYMENT HAS BEEN REDUCED TO RECOVER CAPITATION PAID IN ERROR.
870	YOUR PAYMENT HAS BEEN REDUCED TO OFFSET A TAX LEVY FILED BY THE IRS.

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EOP Message Codes

Code	Message
871	YOUR PAYMENT HAS BEEN REDUCED TO PAY BACKUP WITHHOLDING REQUIRED BY THE IRS.
872	YOUR PAYMENT HAS BEEN REDUCED TO CORRECT YOUR RISK WITHHOLD ACCOUNT.
873	YOUR PAYMENT HAS BEEN REDUCED TO RECOVER A PREVIOUS DEBT.
874	YOUR SUBSCRIBER PAYMENT HAS BEEN REDUCED TO OFFSET A PREVIOUS ADVANCEMENT OF PAYMENT.
875	YOUR PAYMENT HAS BEEN REDUCED TO ADJUST YOUR ACCOUNT. PLEASE CALL FOR DETAILS.
876	PROVIDER: PLEASE SEND US THE NDC #, QUANTITY AND DATE SPAN FOR THIS CLAIM. WE CAN PROCESS THE CLAIM AFTER WE RECEIVE THAT INFORMATION.
882	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE /ADMIT IS NOT MEDICALLY NECESSARY.
883	OUR MEDICAL STAFF DETERMINED THAT THIS CONTINUED STAY IS NOT MEDICALLY NECESSARY.
885	THE SERVICES PROVIDED ARE NOT WITHIN THE SCOPE OF THIS PROVIDER'S LICENSE, AND THEREFORE, ARE NOT COVERED BY THIS PLAN.
886	THE LIFETIME BENEFIT FOR THIS TYPE OF SERVICE HAS BEEN USED, SO NO FURTHER COVERAGE IS AVAILABLE FOR THIS SERVICE.
887	THE MEMBER HAS SATISFIED THE DEDUCTIBLE.
889	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THE WAITING PERIOD HASN'T PASSED YET.
891	THIS MEMBER HAS USED ALL OF HIS/HER BENEFITS.
892	REFUND DUE TO SYSTEM PAYMENT ERROR.
893	REFUND DUE TO CHARGES PROCESSED UNDER INCORRECT SUFFIX/PATIENT.
894	REFUND DUE TO HOSPITAL/PROVIDER CONTRACT INCORRECTLY APPLIED.
895	REFUND DUE TO PAYMENT TO WRONG PAYEE.
896	REFUND DUE TO INCORRECT CODING ON PROVIDER BILLING.
897	CLAIM SHOULD BE BILLED AND PROCESSED THROUGH OAP/BLUECARD.
898	REFUND DUE TO CHARGES BILLED IN ERROR.
899	REFUND DUE TO RETROACTIVE CANCELLATION OF SUBSCRIBER AND/OR DEPENDENTS
AAR	THE PAYMENT WAS AUTOMATICALLY REDUCED FOR RECOVERY OF OVERPAYMENTS OR MANUAL REDUCTIONS.

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EOP Message Codes

Code	Message
B03	THIS CLAIM HAS BEEN SENT TO THE LOCAL BLUE CROSS BLUE SHIELD PLAN PER THE BLUECARD PROGRAM. A NEW EOB WILL BE RECEIVED WHEN COMPLETED.
B05	THE PLAN DOESN'T COVER THIS SERVICE.
B07	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B08	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B09	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B10	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B11	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B12	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B13	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
B18	THIS CHARGE WAS DENIED BASED UPON A REVIEW OF THE RECORDS PROVIDED. THE SERVICES AS BILLED WERE NOT REFLECTED IN THE RECORDS.
B21	MAXIMUM BENEFITS HAVE BEEN PROVIDED WITHOUT 90 DAY BREAK
B24	THIS SERVICE IS NOT A COVERED MEDICAL SERVICE. PLEASE SUBMIT TO A DENTAL VENDOR.
B26	THE PROCEDURE ALLOWANCE IS BASED ON ONE UNIT OF SERVICE
B28	THIS PLAN DOES NOT COVER TEMPORARY DENTAL SERVICES.
B29	DISALLOWED AMOUNT IS PROVIDER WRITE-OFF
B31	MAXIMUM BENEFITS HAVE BEEN PROVIDED FOR THIS CALENDAR YEAR.
B35	THIS DENTAL SERVICE IS CONSIDERED TO BE COSMETIC. THE PLAN DOESN'T COVER COSMETIC SERVICES.
B37	WE CAN'T PROCESS THIS CLAIM BECAUSE WE HAVEN'T RECEIVED THE NECESSARY INFORMATION WE REQUESTED FROM YOUR PROVIDER.
B38	WE CAN'T PROCESS THIS CLAIM BECAUSE WE HAVEN'T RECEIVED YOUR RESPONSE TO OUR REQUEST FOR INFORMATION.
B39	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T COVERED UNDER THE TERMS OF THE PLAN.
B40	THE PLAN DOESN'T COVER POST-OPERATIVE COMPLICATIONS OF A NON-COVERED PROCEDURE.
B41	THE PLAN DOESN'T COVER SERVICES RELATED TO A CONTRACT EXCLUSION.

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EOP Message Codes

Code	Message
B42	THE PLAN DOESN'T COVER PROCEDURES WHOSE EFFECTIVENESS HASN'T YET BEEN PROVEN AND ARE CLASSIFIED AS INVESTIGATIVE.
B43	BENEFITS AREN'T AVAILABLE FOR ANY SERVICE OR SUPPLY THAT HASN'T BEEN CHARGED/BILLED.
B44	THE PLAN DOESN'T COVER SERVICES PERFORMED BY A FAMILY MEMBER.
B45	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T MEDICALLY NECESSARY.
B46	OUR MEDICAL STAFF REQUESTED AND RECEIVED INFORMATION ON THIS CLAIM, BUT THE INFORMATION PROVIDED WAS INCOMPLETE.
B47	BASED ON THE OFFICE RECORDS, A MORE APPROPRIATE CODE WAS USED TO ADMINISTER BENEFITS.
B48	THIS PROVIDER ISN'T ELIGIBLE AS DEFINED UNDER THE TERMS OF THE PLAN.
B49	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T COVERED UNDER THE TERMS OF THE PLAN.
B50	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE INCIDENTAL TO A NON-COVERED PROCEDURE.
B51	THE CHARGE FOR THIS SERVICE SHOULD BE INCLUDED IN THE CHARGE FOR THE PRIMARY PROCEDURE.
B52	AFTER REVIEWING THE AVAILABLE MEDICAL RECORDS, OUR MEDICAL STAFF DETERMINED THAT THIS PROCEDURE WASN'T PERFORMED BY BILLING PROVIDER.
B53	AFTER REVIEWING THE AVAILABLE MEDICAL RECORDS, IT WAS DETERMINED THAT THE RECORDS DO NOT SUPPORT THE BILLED PROCEDURE CODE.
B54	MEDCO PRICED CLAIM
B56	ACCIDENT INFORMATION HAS BEEN RECEIVED. THIS IS AN ADJUSTMENT TO A PREVIOUSLY DENIED CLAIM.
B57	THE PLAN DOESN'T COVER SERVICES PERFORMED BY A FAMILY MEMBER.
B58	BENEFITS BASED ON AN ESTIMATION OF THE PRIMARY CARRIER PAYMENT. PLEASE PROVIDE PRIMARY CARRIER EXPLANATION OF BENEFITS FOR ADJUSTMENTS
B59	OUR DENTAL CONSULTANT HAS REVIEWED THIS CLAIM AND DETERMINED THIS PROCEDURE IS NOT COVERED UNDER YOUR PLAN.
B68	REFUND DUE TO INCORRECT CODING ON PROVIDER BILLING.
B69	REFUND DUE TO INCORRECT CODING ON PROVIDER BILLING.
B72	REFUND DUE TO CHARGES BILLED IN ERROR
B73	REFUND DUE TO CHARGES BILLED IN ERROR.

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EOP Message Codes

Code	Message
B74	REFUND DUE TO WRONG SUBSCRIBER CONTRACT BENEFIT.
B75	REFUND DUE TO WRONG SUBSCRIBER CONTRACT BENEFIT.
B76	REFUND DUE TO COORDINATION OF BENEFITS WITH OTHER CARRIER.
B78	REFUND RECEIVED FOR DUPLICATE PAYMENT ON A CLAIM.
B79	REFUND RECEIVED FOR DUPLICATE PAYMENT ON A CLAIM.
B92	ADJUSTMENT DUE TO INCORRECT CODING ON PROVIDER BILLING.
B93	ADJUSTMENT DUE TO INCORRECT CODING ON PROVIDER BILLING.
B94	ADJUSTMENT DUE TO INCORRECT CODING ON PROVIDER BILLING.
B95	CLAIM SHOULD BE BILLED AND PROCESSED THROUGH OAP/BLUECARD.
B96	CLAIM SHOULD BE BILLED AND PROCESSED THROUGH OAP/BLUECARD.
B97	CLAIM SHOULD BE BILLED AND PROCESSED THROUGH OAP/BLUECARD.
B98	ADJUSTMENT DUE TO CHARGES BILLED IN ERROR.
B99	ADJUSTMENT DUE TO CHARGES BILLED IN ERROR.
BA1	CONVALESCENT OR CUSTODIAL CARE IS NOT COVERED.
BA2	PLEASE RESUBMIT WITH ACCURATE EXPLANATION OF MEDICARE BENEFITS. THE EOMB SUBMITTED DOES NOT MATCH THE SERVICES ON THE CLAIM.
BA3	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM THE PROVIDER
BA4	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM SUBSCRIBER
BA8	FOREIGN TRAVEL CARE MUST BEGIN DURING THE FIRST 60 DAYS YOU ARE OUTSIDE THE USA.
BA9	PROVIDER: THIS CODE IS NOT LISTED IN YOUR FEE SCHEDULE.
BB1	COVERED MEDICAL EXPENSES HAVE BEEN REDUCED BY ANY BENEFITS PAYABLE UNDER PART A AND/OR PART B OF MEDICARE.
BB2	PROVIDER WRITE-OFF AMOUNT IS DETERMINED BY MEDICARE RULES.
BB3	THIS AMOUNT IS YOUR RESPONSIBILITY TO PAY.
BB9	THE AMOUNT PREVIOUSLY CREDITED TO YOUR DEDUCTIBLE WAS INCORRECT. THIS CLAIM HAS BEEN ADJUSTED TO THE CORRECT DEDUCTIBLE AMOUNT.
BC1	THE MEMBER IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN BILLED CHARGES AND PAID

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EOP Message Codes

Code	Message
	AMOUNTS.
BC2	THIS CLAIM APPEARS TO BE A CORRECTED BILLING OF A PREVIOUSLY SUBMITTED CLAIM. PLEASE RESUBMIT WITH THE CORRECTED MEDICARE EOMB.
BC3	WE ARE UNABLE TO DETERMINE THE MEDICARE NON-COVERED LINE ITEMS. PLEASE RESUBMIT WITH MEDICARE NON-COVD CHGS CLEARLY ID'D ON THE UB92.
BC4	THIS PLAN DOESN'T PROVIDE BENEFITS ON THE AMOUNT APPLIED TO MEDICARE'S PART B DEDUCTIBLE.
BC5	THIS PLAN DOESN'T PROVIDE BENEFITS ON THE AMOUNT APPLIED TO MEDICARE'S PART A DEDUCTIBLE.
BC6	A MEDICARE SUPPLEMENTAL CALCULATION HAS BEEN APPLIED.
BC7	UNLICENSED PROVIDERS ARE NOT COVERED
BC8	NOT A COVERED SERVICE - SUBMIT TO YOUR MEDICAL VENDOR.
BCO	THIS CLAIM HAS BEEN COORDINATED WITH YOUR OTHER CARRIER.
BD0	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BD2	THE MAXIMUM BENEFIT LIMIT HAS BEEN PROVIDED FOR THIS PLAN YEAR.
BD3	THE BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
BD4	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BD5	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BD6	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BD7	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BD8	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BD9	THE MAXIMUM TRAVEL BENEFIT FOR THIS SERVICE HAS BEEN PROVIDED FOR THIS BENEFIT YEAR.
BE1	MEDICAL REVIEW IS REQUIRED FOR CHIROPRACTIC SERVICES AFTER THE 20TH VISIT.
BE2	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE DOES NOT MEET THE CRITERIA FOR MEDICAL NECESSITY.
BE3	THE AUDIO BENEFIT MAXIMUM HAS BEEN MET.
BE4	THE AUDIO BENEFIT MAXIMUM HAS BEEN MET.
BE5	THE VISION HARDWARE BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
BE6	SERVICE PROVIDED BY OUT-OF-NETWORK PROVIDER THEREFORE SERVICE PENALTY OF 20% APPLIED.

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EOP Message Codes

Code	Message
BE7	CERTIFICATION SERVICE PENALTY
BE8	CERTIFICATION/OR REFERRAL PENALTY
BE9	SERVICE PROVIDED BY OUT-OF-NETWORK PROVIDER THEREFORE CERTIFICATION PENALTY APPLIED.
BF0	COSMETIC PROCEDURES ARE NOT ELIGIBLE PER IRS REGULATIONS.
BF1	SERVICE PROVIDED BY OUT-OF-NETWORK PROVIDER THEREFORE SERVICE PENALTY OF 20% APPLIED.
BF2	CERTIFICATION PENALTY, SERVICE NOT COVERED
BF3	CERTIFICATION PENALTY, SERVICE NOT COVERED
BF4	CERTIFICATION FOR THIS SERVICE HAS BEEN DENIED
BF5	TRAVEL PRE-AUTHORIZATION NOT RECEIVED, THEREFORE NOT COVERED.
BF6	SERVICE PENALTY FOR NON-EMERGENCY VISIT
BF7	CERTIFICATION PENALTY APPLIED. THE BENEFIT HAS BEEN REDUCED FOR THIS SERVICE.
BF8	NOT AN ELIGIBLE EXPENSE UNDER YOUR EMPLOYER'S FSA PLAN.
BF9	NOT AN ELIGIBLE EXPENSE PER IRS REGULATIONS.
BG0	INSURANCE PREMIUMS ARE NOT ELIGIBLE PER IRS REGULATIONS.
BG1	ELIGIBLE EXPENSES MUST BE INCURRED DURING THE PLAN YEAR.
BG2	EXPENSES FOR FUTURE DATES OF SERVICE ARE NOT ALLOWED. PLEASE SUBMIT A NEW CLAIM ONCE THE SERVICE HAS BEEN RENDERED.
BG3	CLAIM WAS RECEIVED AFTER THE LAST DATE ALLOWED BY YOUR PLAN.
BG4	DATE OF SERVICE IS OUTSIDE YOUR PERIOD OF ELIGIBILITY UNDER THE PLAN.
BG5	DATE OF SERVICE IS AFTER YOUR PLAN'S TERMINATION DATE.
BG6	AMOUNT REQUESTED DID NOT MATCH YOUR DOCUMENTATION. REIMBURSEMENT AMOUNT WAS BASED ON THE DOCUMENTATION YOU PROVIDED.
BG7	AMOUNTS PAID BY INSURANCE ARE NOT ELIGIBLE FOR REIMBURSEMENT.
BG8	PROVIDER DISCOUNTS ARE NOT ELIGIBLE FOR REIMBURSEMENT.
BG9	THIS EXPENSE WAS ALREADY REIMBURSED IN A PRIOR CLAIM.
BH0	ALL AVAILABLE FUNDS HAVE BEEN APPLIED. YOUR ACCOUNT IS NOW EXHAUSTED.
BH1	ONLY QUANTITIES THAT CAN REASONABLY BE CONSUMED DURING THE PLAN YEAR MAY BE REIMBURSED.

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EOP Message Codes

Code	Message
	STOCKPILING IS NOT ALLOWED.
BH2	EXPENSES IN EXCESS OF REASONABLE AMOUNTS ARE NOT ELIGIBLE. REIMBURSEMENT WAS FOR THE MAXIMUM ALLOWED.
BH3	THIS EXPENSE IS NOT ELIGIBLE FOR REIMBURSEMENT.
BH5	THE VISION HARDWARE BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
BH6	CERTIFICATION/REFERRAL FOR THIS SERVICE HAS BEEN DENIED.
BH7	CERTIFICATION/REFERRAL PENALTY, SERVICE NOT COVERED.
BH8	CERTIFICATION/REFERRAL PENALTY, SERVICE NOT COVERED.
BH9	REIMBURSEMENT AMOUNT LIMITED PER IRS/PLAN RULES.
BI0	THE BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
BI2	NON EMERGENCY AND OUT-OF-NETWORK PENALTIES APPLIED.
BI3	FOOD AND/OR LODGING IS COVERED FOR PATIENT ONLY.
BI4	THIS SERVICE IS COVERED FOR PRE-OPERATIVE TESTING AND SURGERY ONLY.
BI6	MEDICAL REVIEW IS REQUIRED FOR PHYSICAL THERAPY SERVICES AFTER THE 20TH VISIT.
BI7	MEDICAL REVIEW IS REQUIRED FOR PHYSICAL THERAPY SERVICES AFTER THE 20TH VISIT.
BI8	THE VISION PLAN DOES NOT COVER THIS MEDICAL/AUDIO SERVICE.
BI9	THE VISION PLAN DOES NOT COVER THIS MEDICAL/AUDIO SERVICE.
BJ0	THE MEDICAL PLAN DOES NOT COVER THIS VISION SERVICE.
BJ1	THE MEDICAL PLAN DOES NOT COVER THIS VISION SERVICE.
BJ2	THE CHARGES FOR THIS SERVICE HAVE BEEN COMBINED INTO THE PRIMARY PROCEDURE BASED ON THE PROVIDERS CONTRACT.
BJ3	THIS SERVICE IS NOT COVERED WHEN PERFORMED WITHIN THE FIRST SIX MONTHS OF PLACEMENT OF PROSTHETIC.
BJ4	WE ARE UNABLE TO PROCESS YOUR CLAIM AS A COMPLETED MEDICARE QUESTIONNAIRE HAS NOT BEEN RETURNED.
BJ5	THIS PROVIDER IS PART OF THE MULTIPLAN NETWORK AND MULTIPLAN DISCOUNT PRICING APPLIED.
BJ6	THIS PROVIDER IS PART OF THE MULTIPLAN NETWORK AND MULTIPLAN DISCOUNT PRICING APPLIED.
BJ7	THIS PROVIDER IS PART OF THE CCN/FIRST HEALTH NETWORK AND CCN/FIRST HEALTH DISCOUNT PRICING

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EOP Message Codes

Code	Message
	APPLIED.
BJ8	THE PLAN DOESN'T COVER THIS SERVICE
BJ9	THE PLAN DOESN'T COVER THIS SERVICE.
BK0	WHEN WE RECEIVE THE COMPLETED OTHER COVERAGE QUESTIONNAIRE, WE WILL REPROCESS THE CLAIM(S).
BK1	WE NEED INFORMATION FROM THE MBR'S OTHER INSURANCE CARRIER TO PROCESS THIS CLAIM. PLEASE SEND US THE OTHER CARRIER'S EXPLANATION OF BENEFITS
BK2	THIS PROVIDER IS PART OF THE CCN/FIRST HEALTH NETWORK AND CCN/FIRST HEALTH DISCOUNT PRICING APPLIED.
BK3	SURGICAL DENTAL IMPLANTS NECESSARY DUE TO DISEASE OR ACCIDENT ARE REVIEWED AND PROCESSED UNDER THE MEMBER'S MEDICAL PLAN.
BK4	PROCESSED AS PARTICIPATING PROVIDER FOR SERVICE DATES OF 7/1/06 - 8/31/2006 ONLY.
BK5	THE PROVIDER ISN'T A CREDENTIALED AMBULATORY SURGERY CENTER.
BK7	THIS CLAIM CANNOT BE PROCESSED UNTIL PRIMARY CARRIER PAYMENT INFORMATION IS RECEIVED.
BK8	WE CANNOT PROCESS THIS CLAIM UNTIL THE STUDENT ELIGIBILITY LETTER HAS BEEN COMPLETED AND RETURNED FROM OUR MEMBER.
BK9	THE DEPENDENT DOES NOT MEET THIS PLAN'S STUDENT ELIGIBILITY REQUIREMENTS.
BL0	WE CANNOT PROCESS THIS CLAIM UNTIL THE STUDENT ELIGIBILITY LETTER HAS BEEN COMPLETED AND RETURNED.
BL1	THE DEPENDENT DOES NOT MEET THIS PLANS STUDENT ELIGIBILITY REQUIREMENTS.
BL3	THE ALLOWED AMOUNT IS GREATER THAN THE BILLED AMOUNT RESULTING IN A NEGATIVE LINE.
BL4	PRICED PER 30% PLAN
BL5	A DATA ISSUE EXISTED THAT CAUSED MEDICARE TO DENY THIS CLAIM INCORRECTLY. WE ARE REQUESTING THAT THE PROVIDER RESUBMIT THIS CLAIM.
BL6	NEWBORN SERVICES PROVIDED AFTER 72 HOURS ARE NOT COVERED BY THIS PLAN.
BL7	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
BL8	REPAIRS TO DENTURES AND BRIDGES ARE COVERED ONCE IN ANY TWO YEAR PERIOD.
BL9	REPAIRS WITHIN ONE YEAR AFTER THE INITIAL PLACEMENT OF THE APPLIANCE ARE NOT COVERED.
BM0	DENTURE RELINE, REBASE AND ADJUSTMENT IS LIMITED UNDER THIS PLAN.

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EOP Message Codes

Code	Message
BM1	RELINING OR REBASING PERFORMED WITHIN ONE YEAR OF THE INITIAL PLACEMENT OF THE EXISTING DENTURE IS NOT COVERED.
BM2	CLAIM CLOSED UNTIL MEMBER RETURNS COMPLETED PRE-EXISTING QUESTIONNAIRE
BM3	PEACE HEALTH-PRE-AUTHORIZATION IS REQUIRED, THIS SERVICE IS NOT COVERED.
BM4	OON ALT. PROVIDER IN OREGON PAY AT INN BENEFIT LEVEL AT BILLED CHARGES
BM7	NON-COVERED CHARGES ARE INDICATED ON THE UB92 BUT NOT ON THE EOMB. PLEASE RESUBMIT CORRECTED EOMB.
BQ6	THIS ADJUSTMENT IS A RESULT OF A MEDICARE MISTAKEN PRIMARY PAYMENT.
BR1	PREFERRED ONE RATES APPLIED
BR2	PREFERRED ONE RATES APPLIED
BR4	REPLACEMENT OF AN EXISTING CROWN, INLAY, ONLAY OR LABIAL VENEER IS LIMITED. PLEASE REFER TO YOUR BENEFIT BOOKLET.
BR5	REPLACEMENT OF AN EXISTING PARTIAL, FIXED BRIDGEWORK, OR COMPLETE DENTURE IS LIMITED. PLEASE REFER TO YOUR BENEFIT BOOKLET.
BS1	NO RECORD OF NEWBORN ENROLLMENT
BS2	WE CANNOT PROCESS THIS CLAIM UNTIL THE CERTIFICATION OF DISABLED DEPENDENT FORM HAS BEEN COMPLETED AND RETURNED.
BS4	IF YOU USE A NETWORK PHARMACY, THE PHARMACY WILL SUBMIT YOUR CLAIM FOR YOU AND YOUR BILLED AMOUNT MAY REFLECT SAVINGS.
BS5	BY USING A NETWORK PROVIDER, YOUR BILLED AMOUNT MAY REFLECT SAVINGS.
BS6	THE PLAN DOESN'T COVER FILLINGS ON THE SAME TOOTH MORE THAN ONCE EVERY 2 CALENDAR YEARS
BS7	NEW INSURANCE CARRIER. PLEASE CONTACT THE SUBSCRIBER'S EMPLOYER FOR INSTRUCTIONS ON RESUBMITTING THIS CLAIM TO THE NEW INSURANCE CARRIER.
BS8	ENTIRE CLAIM PROCESSED ON THE PREMERA COVERAGE IN EFFECT AT THE TIME OF ADMIT
BT8	CLAIM DENIED, ADMIT DATE PRIOR TO EFFECTIVE DATE. IF MEMBER IS HIPAA ELIGIBLE (SEE BENEFIT BOOKLET) RESUBMIT WITH ELIGIBILITY REQUIREMENTS.
BT9	THESE CHARGES ARE AFTER YOUR COVERAGE TERM DATE. ANOTHER CARRIER MAY BE RESPONSIBLE. SEE THE EXTENDED BENEFITS SECTION OF YOUR POLICY.
BU4	THE PLAN DOES NOT COVER SERVICES PERFORMED BY A FAMILY MEMBER.
BU5	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.

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EOP Message Codes

Code	Message
BU7	WE CANNOT PROCESS THIS CLAIM UNTIL THE CERTIFICATION OF DISABLED DEPENDENT FORM HAS BEEN COMPLETED AND RETURNED FROM OUR MEMBER.
BU8	THE MEMBER'S BREAKPOINT MAXIMUM WAS MET.
BV1	NON-NETWORK NATUROPATH PAID AT IN-NETWORK BENEFIT LEVEL.
BV2	THIS IS A STATE OF ALASKA CLAIM
BV3	THIS MEMBER WASN'T ELIGIBLE FOR SERVICES ON THE DATE OF SERVICE.
BV4	THE SERVICES PROVIDED ARE NOT WITHIN THE SCOPE OF THIS PROVIDER'S LICENSE, AND THEREFORE, ARE NOT COVERED BY THIS PLAN.
BV5	OUR MEDICAL STAFF DETERMINE THE MAXIMUM LIMIT HAS BEEN MET FOR THIS BENEFIT.
BV6	MAXIMUM BENEFITS HAVE BEEN PROVIDED FOR THIS CALENDAR YEAR.
BV7	THIS PROVIDER ISN'T ELIGIBLE AS DEFINED UNDER THE TERMS OF THE PLAN.
BV8	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM SUBSCRIBER.
BV9	THIS CANNOT BE PROCESSED UNTIL CHARGES ARE FILED WITH OTHER INSURANCE.
BW1	DUPLICATE LINE PREVIOUSLY PROCESSED.
BW2	NON-NETWORK ACUPUNTURE/MANIPULATION SERVICES PAID AT IN-NETWORK BENEFIT LEVEL.
BW4	PAYMENT WAS REDUCED DUE TO PRIOR CARRIER PLAN PAYMENTS.
BW7	THE UNIT PRICE HAS BEEN BUNDLED FOR NEGOTIATED SAVINGS AND MAY RESULT IN A NEGATIVE LINE ITEM. IT DOES NOT AFFECT YOUR COVERAGE.
BW8	REVENUE CODE NO LONGER VALID.
BW9	THIS PLAN DOES NOT COORDINATE BENEFITS FOR PHARMACY SERVICES.
BX1	BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE. CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
BX2	WE ARE UNABLE TO PROCESS THIS CLAIM UNTIL THE DISABILITY ELIGIBILITY LETTER HAS BEEN COMPLETED AND RETURNED.
BX3	THE MEMBER IS OLDER THAN THE PLAN'S STUDENT AGE LIMIT ALLOWS.
BX4	THE DEPENDENT DOES NOT MEET THIS PLANS STUDENT ELIGIBILITY REQUIREMENTS.
BX5	WE ARE UNABLE TO PROCESS THIS CLAIM UNTIL THE STUDENT ELIGIBILITY LETTER HAS BEEN COMPLETED AND RETURNED.

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EOP Message Codes

Code	Message
BX6	PAYMENT IS BASED ON THE LESSER OF DSHS PAYMENT OR THE MEMBERS CONTRACTED BENEFIT FOR THIS SERVICE.
BX7	PAYMENT IS RESULT OF MEDICAID MISTAKEN PRIMARY PAYMENT. AMOUNT IS DIFFERENCE BETWEEN DSHS PAID AND MEMBERS BENEFIT.
BX8	THIS CODE IS DEFINED AS A TECHNICAL PROCEDURE CODE THEREFORE PROFESSIONAL SERVICES ARE NOT REIMBURSED SEPARATELY.
BY3	OUR ALLOWED AMOUNT WAS ADJUSTED TO THE OTHER CARRIER ALLOWED AMOUNT
BY5	CODE BILLED WITH MULTIPLE UNITS ON ONE LINE HAS BEEN CHANGED TO MULTIPLE LINES WITH ONE UNIT EACH.
BY6	NON PPO PROVIDER - FEES ABOVE ALLOWED AMOUNT ARE MEMBER RESPONSIBILITY
BY7	A COMPLETE MEDICARE EXPLANATION OF BENEFITS IS REQUIRED AND WAS NOT RECEIVED WITH THE CLAIM SUBMITTED.
BY8	PRICED PER PROVIDER CONTRACT OR AGREEMENT
BY9	NON PPO PROVIDER - FEES ABOVE ALLOWED AMOUNT ARE MEMBER RESPONSIBILITY
BZ4	PRIOR-AUTHORIZATION NOT OBTAINED. PENALTY APPLIED.
BZ5	CLAIM/CHARGE APPROVED PER APPEAL OUTCOME - CLAIM ADJUSTMENT
BZ6	CLAIM/CHARGE APPROVED PER APPEAL OUTCOME - CLAIM ADJUSTMENT
BZ7	PREVIOUSLY DENIED SERVICE - SETTLEMENT - NO ACTION REQUIRED.
BZ8	DUPLICATE CLAIM PREVIOUSLY PROCESSED. PROVIDERS ONLY - REFER TO RA REMARK CODE MA18 ON YOUR EOMB.
BZ9	DUPLICATE CLAIM PREVIOUSLY PROCESSED. PROVIDERS ONLY - REFER TO RA REMARK CODE MA18 ON YOUR EOMB.
CA1	DUPLICATE OF CLAIM SUBMITTED BY PROVIDER OF SERVICE AND BENEFITS PAID TO PROVIDER.
CA2	THIS IS A DUPLICATE TO A PREVIOUS CLAIM APPLIED TO THE MEMBERS DEDUCTIBLE.
CA3	THE MEMBER IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN BILLED CHARGES AND ALLOWED CHARGES WHEN THE SERVICE PROVIDER IS OUT-OF-NETWORK.
CA4	TRAVEL IS NOT COVERED WHEN THE RELATED MEDICAL CLAIM IS NOT RECEIVED.
CA5	THIS BENEFIT HAS BEEN REDUCED SINCE THE COST EXCEEDS ROUND TRIP COACH CLASS AIRFARE.
CA6	MEDICAL REVIEW DETERMINED THIS TRAVEL WAS NOT NECESSARY FOR THIS CLAIM.

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EOP Message Codes

Code	Message
CA7	PLEASE RESUBMIT CLAIM WITH THE PROVIDERS ORIGINAL CHARGES, ALONG WITH THE DSHS ALLOWED AND PAID AMOUNTS.
CA8	ORTHODONTIA BENEFIT APPLIED
CA9	BENEFITS ADMINISTERED PER CONTINUITY OF CARE PROVISION.
CB1	CHARGES ARE BASED ON YOUR PARTICIPATION IN THE MEDICARE ADVANTAGE RAP PROGRAM.
CB3	PLEASE RESUBMIT WITH THE DSHS PAID AMOUNT FOR EACH LINE ITEM BILLED.
CB4	YOUR CALENDAR YEAR LIMIT FOR PREVENTIVE CARE HAS BEEN REACHED. NO ADDITIONAL BENEFITS ARE AVAILABLE.
CB5	THIS IS NOT AN ALLOWED CHARGE
CB6	DISALLOWED AMOUNT
CB7	LINE LEVEL DATE OF SERVICE HAS BEEN CHANGED TO ADMINISTER THIS MEDICARE ADVANTAGE RAP PROGRAM CLAIM.
CB8	ZERO FREQUENCY BILLED/NO PAYMENT ANTICIPATED BY PROVIDER.
CB9	NEW INSURANCE CARRIER. PLEASE CONTACT THE SUBSCRIBER'S EMPLOYER FOR INSTRUCTIONS ON RESUBMITTING THIS CLAIM TO THE NEW INSURANCE CARRIER.
CBI	COB INFORMATION NOT RECEIVED
CBN	PRIMARY CARRIER PAYMENT INFORMATION REQUIRED
CC1	FUNDUS PHOTOGRAPHY-NOT MEDICALLY NECESSARY DURING A ROUTINE VISION EXAM VISIT.
CC3	THE MEDICAL PLAN DOES NOT COVER THIS VISION SERVICE
CC4	THE MEDICAL PLAN DOES NOT COVER THIS DENTAL SERVICE
CC5	THE VISION PLAN DOES NOT COVER THIS MEDICAL SERVICE
CC6	THE VISION PLAN DOES NOT COVER THIS DENTAL SERVICE
CC7	IDAHO PHYSICIAN'S NETWORK (IPN) DISCOUNT PRICING APPLIED.
CC9	IDAHO PHYSICIAN'S NETWORK (IPN) DISCOUNT PRICING APPLIED.
CD1	PLEASE RESUBMIT WITH ACCURATE EXPLANATION OF MEDICARE BENEFITS. THE EOMB SUBMITTED DOES NOT MATCH THE SERVICES ON THE CLAIM.
CD2	THIS CLAIM APPEARS TO BE A CORRECTED BILLING OF A PREVIOUSLY SUBMITTED CLAIM. PLEASE RESUBMIT WITH THE CORRECTED MEDICARE EOMB.

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EOP Message Codes

Code	Message
CD3	WE ARE UNABLE TO DETERMINE THE MEDICARE NON-COVERED LINE ITEMS. PLEASE RESUBMIT WITH MEDICARE NON-COVD CHGS CLEARLY ID'D ON THE UB92.
CD4	SERVICES BY A MASSAGE THERAPIST REQUIRE A PROVIDER PRESCRIPTION.
CD5	DIAGNOSIS ON THE CLAIM DOES NOT MATCH THE DIAGNOSIS ON THE PRESCRIPTION ON FILE.
CD6	THE PRESCRIPTION IS ILLEGIBLE.
CD7	SERVICES BY A MASSAGE THERAPIST REQUIRE A PROVIDER PRESCRIPTION.
CD8	DIAGNOSIS ON THE CLAIM DOES NOT MATCH THE DIAGNOSIS ON THE PRESCRIPTION ON FILE.
CD9	THE PRESCRIPTION IS ILLEGIBLE.
CDD	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
CE0	OBSTETRICAL BENEFITS NOT AVAILABLE UNTIL YOU HAVE BEEN ENROLLED ON THIS PLAN FOR 12 CONSECUTIVE MONTHS.
CE1	OBSTETRICAL BENEFITS NOT AVAILABLE UNTIL YOU HAVE BEEN ENROLLED ON THIS PLAN FOR 12 CONSECUTIVE MONTHS.
CE2	TRANSPLANT BENEFITS NOT AVAILABLE UNTIL YOU HAVE BEEN ENROLLED ON THIS PLAN FOR 12 CONSECUTIVE MONTHS.
CE3	TRANSPLANT BENEFITS NOT AVAILABLE UNTIL YOU HAVE BEEN ENROLLED ON THIS PLAN FOR 12 CONSECUTIVE MONTHS.
CE4	WE CAN NOT PROCESS THIS CLAIM UNTIL WE HAVE RECEIVED THE AUTO CARRIER'S EXPLANATION OF REVIEW AND/OR PAYMENT.
CE5	YOUR EMPLOYER HAS A DIRECT CONTRACT WITH THIS PROVIDER. PLEASE SUBMIT THIS CLAIM TO YOUR EMPLOYER FOR PROCESSING.
CE6	SERVICES BY A MASSAGE THERAPIST REQUIRE A PROVIDER PRESCRIPTION.
CE7	MASSAGE THERAPY PRESCRIPTION RECEIVED DOES NOT COVER THE DATE OF SERVICE.
CE8	MASSAGE THERAPY PRESCRIPTION RECEIVED DOES NOT COVER THE DATE OF SERVICE.
CG0	THE PLAN DOESN'T COVER THIS DENTAL SERVICE.
CG1	THE PLAN DOESN'T COVER THIS DENTAL SERVICE.
CG2	THE CHARGE EXCEEDS THE COVERED AMOUNT FOR THE DENTAL SERVICE.
CG3	THE CHARGE AMOUNT EXCEEDS THE COVERED AMOUNT FOR THE DENTAL SERVICE.
CG4	THE COVERED AMOUNT IS GREATER THAN THE ALLOWED AMOUNT.

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EOP Message Codes

Code	Message
CG5	THE COVERED AMOUNT IS GREATER THAN THE ALLOWED AMOUNT.
CVX	THE PLAN EXCLUDES COVERAGE FOR THIS SERVICE.
D24	THE PLAN LIMITS BENEFITS FOR PERIODONTAL MAINTENANCE.
D25	CLAIM HAS BEEN REVIEWED BY THE DENTAL TEAM.
D26	DENTAL BENEFITS ARE NOT COVERED UNDER THE PATIENT'S BENEFIT PLAN OR POLICY.
D27	THE PLAN DOESN'T COVER DENTAL SERVICES.
D28	PLEASE RESUBMIT AMBULATORY SURGICAL CENTER, SURGERY SUITE, OR FACILITY FEE SEPARATELY WITH THE CORRECT CPT CODE AND MODIFIER IF APPLICABLE.
D29	A REQUIRED WAITING PERIOD MUST PASS BEFORE WE CAN PROVIDE BENEFITS FOR THIS ORTHODONTIA SERVICE.
D30	PAYMENT FOR INITIAL ORTHODONTIA BANDING OR DOWNPAYMENT FEE ONLY.
D31	THE ALLOWABLE AMOUNT FOR THIS SERVICE HAS BEEN REDUCED TO DSHS PAID AMOUNT.
D32	PAYMENT IS RESULT OF MEDICAID MISTAKEN PRIMARY PAYMENT. AMOUNT IS DIFFERENCE BETWEEN DSHS PAID AND MEMBERS BENEIFT.
D33	OUR RECORDS SHOW THAT THIS TOOTH WAS RECENTLY RESTORED. NO ADDITIONAL BENEFITS CAN BE ALLOWED.
D34	THIS PLAN DOESN'T COVER PROSTHETICS.
D35	THE PLAN LIMITS BENEFITS FOR PERIODONTAL SCALING AND ROOT PLANING
D36	ALLOWANCE APPLIED BASED ON ACTUAL SERVICES RENDERED.
D37	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE OF A ONE SURFACE FILLING.
D38	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE OF A TWO SURFACE FILLING.
D39	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE OF A THREE SURFACE FILLING.
D40	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE OF A FOUR OR MORE SURFACE FILLING.
D41	REPAIR, RECEMENT, RELINE, REBASE AND ADJUSTMENT IS LIMITED UNDER THIS PLAN
D42	THIS PLAN HAS A MISSING TOOTH EXCLUSION. THE REPLACEMENT OF A MISSING TOOTH OR TEETH EXTRACTED PRIOR TO YOUR EFFECTIVE DATE IS NOT COVERED.

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EOP Message Codes

Code	Message
D43	SERVICE WAS NOT SUBMITTED ACCORDING TO CURRENT CDT NOMENCLATURE AND / OR DESCRIPTOR APPROVED BY THE AMERICAN DENTAL ASSOCIATION
D44	THE PLAN LIMITS BENEFITS FOR FULL MOUTH DEBRIDEMENT
D45	THE PLAN LIMITS BENEFITS FOR PERIODONTAL SURGERY
D46	THE PLAN LIMITS BENEFITS FOR NIGHTGUARDS
D47	THE PLAN LIMITS BENEFITS FOR PREFABRICATED STAINLESS STEEL CROWNS
D48	THE PLAN LIMITS BENEFITS FOR ROOT CANAL THERAPY
D49	THIS PLAN HAS A MISSING TOOTH EXCLUSION. BASED ON THE INFORMATION SUBMITTED THE ABUTMENT TOOTH CAN BE ALLOWED BASED ON OWN MERIT.
D50	THIS PLAN HAS A MISSING TOOTH EXCLUSION. OUR DENTAL CONSULTANT HAS APPLIED AN ALTERNATIVE ALLOWANCE TO THE ABUTMENT TOOTH.
D51	THIS PLAN HAS A MISSING TOOTH EXCLUSION. OUR CONSULTANT DETERMINED THERE ARE NO BENEFITS FOR THE ABUTMENT TOOTH BASED ON OWN MERIT.
D52	THIS PLAN LIMITS BENEFITS FOR DIAGNOSTIC CASTS AND/OR STUDY MODELS.
D53	THIS PLAN LIMITS BENEFITS FOR RECEMENT.
D54	THIS PLAN LIMITS BENEFITS FOR REPAIR.
D55	THIS PLAN LIMITS BENEFITS FOR COMPLETE OCCLUSAL ADJUSTMENTS.
D56	THIS PLAN LIMITS BENEFITS FOR IMPLANT AND/OR IMPLANT RELATED SERVICES.
D57	THIS PLAN HAS A MISSING TOOTH EXCLUSION. PLEASE PROVIDE EXTRACTION DATES OF ALL MISSING TEETH, INITIAL OR PRIOR PLACEMENT DATE.
D58	THIS PLAN HAS A MISSING TOOTH EXCLUSION. PLEASE PROVIDE EXTRACTION DATE OF THE MISSING TOOTH.
D59	THIS PLAN HAS A MISSING TOOTH EXCLUSION. PLEASE PROVIDE EXTRACTION DATES OF ALL MISSING TEETH.
D60	THIS IS AN ELECTIVE SERVICE THAT IS CONSIDERED PART OF AN ORAL EXAMINATION. NO ADDITIONAL BENEFITS ARE ALLOWED.
D61	OUR PERIODONTAL CONSULTANT REVIEWED THIS CASE AND DETERMINED BENEFITS BASED ON THE SITES OF RECESSION OR OSSEOUS DEFECT.
D62	OUR DENTAL CONSULTANT REVIEWED AND DETERMINED APPLIANCES PRIMARILY FOR BRUXISM (CLENCHING AND GRINDING) ARE NOT COVERED BY THE MEDICAL PLAN.

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EOP Message Codes

Code	Message
D63	SURGICAL EXTRACTION OF TEETH IS NOT COVERED UNDER THIS MEDICAL PLAN FOR THE DIAGNOSIS SUBMITTED.
D64	PLEASE RESUBMIT THIS CLAIM WITH DIAGNOSIS AND DESCRIPTION OF THE TYPE OF SURGICAL EXTRACTION PERFORMED.
D65	PLEASE RESUBMIT THIS CLAIM WITH A DIAGNOSIS OR NARRATIVE OF CONDITION AND/OR PATHOLOGY OR OPERATIVE REPORT IF APPLICABLE.
D74	THIS PROCEDURE CODE IS NOT COVERED WHEN USED FOR IMMEDIATE FILL OF EXTRACTION SOCKET TO PRESERVE RIDGE INTEGRITY.
D75	BENEFITS ARE NOT COVERED FOR GUIDED TISSUE REGENERATION IN AN EXTRACTION SITE AS AN ADJUNCT TO NORMAL HEALING.
D76	OUR DENTAL CONSULTANT HAS DETERMINED BENEFITS ARE NOT COVERED SINCE MED OR DENTAL NECESSITY IS NOT EVIDENT FROM SUBMITTED DOCUMENTATION.
D77	SERVICES CONSIDERED INVESTIGATIONAL, EXPERIMENTAL OR THAT HAVE NOT BEEN FDA APPROVED FOR THIS USE ARE NOT COVERED.
DAP	THE ORIGINALLY SUBMITTED PROCEDURE WAS REPLACED DUE TO PLAN RESTRICTIONS.
DIS	A DISCOUNT WAS APPLIED TO THIS CLAIM.
DP0	THE MEMBER EXCEEDS THE PLAN MAXIMUM AGE FOR THIS SERVICE. PLEASE REFER TO THE BENEFITS SECTION OF YOUR POLICY.
DP1	THIS DENTAL PROCEDURE IS NOT VALID FOR THE TOOTH/TEETH.
DP2	THE CHARGE EXCEEDS THE COVERED AMOUNT FOR THE DENTAL SERVICE.
DP3	THE COVERED AMOUNT IS GREATER THAN THE PROCEDURE'S ALLOWED AMOUNT PLUS THE RELATED DENTAL CLAIM HISTORY (INCLUDING CURRENT CLAIM).
DP4	THE COVERED AMOUNT IS GREATER THAN THE PROCEDURE'S ALLOWED AMOUNT.
DP5	THE COVERED AMOUNT IS GREATER THAN THE PROCEDURE'S ALLOWED AMOUNT AND RELATED DENTAL HISTORY (INCLUDING CURRENT CLAIM).
DY3	OUR ALLOWED AMOUNT WAS ADJUSTED TO THE OTHER CARRIER ALLOWED AMOUNT
DY8	PRICED PER PROVIDER CONTRACT OR AGREEMENT
E01	THIS SERVICE IS INCLUDED IN YOUR SWEDISH MEDICAL HOME PROGRAM
E02	THIS SERVICE IS INCLUDED IN YOUR MULTICARE PROGRAM - NO ACTION NECESSARY
E03	THIS SERVICE IS INCLUDED IN YOUR EVERETT CLINIC PROGRAM - NO ACTION NECESSARY

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EOP Message Codes

Code	Message
E04	COORDINATION OF BENEFITS INFORMATION REQUIRED
E05	GOVERNMENT SUPPLIED VACCINE PROVIDED AT NO COST TO THE PROVIDER
E07	THIS SERVICE IS INCLUDED IN YOUR SWEDISH MEDICAL HOME PROGRAM
E08	THIS SERVICE IS INCLUDED IN YOUR MULTICARE PROGRAM - NO ACTION NECESSARY
E09	THIS SERVICE IS INCLUDED IN YOUR EVERETT CLINIC PROGRAM - NO ACTION NECESSARY
E10	PURCHASE OF THIS ITEM IS NOT COVERED UNDER THE MEMBER'S BENEFIT PLAN.
E11	THE MAXIMUM AMOUNT FOR THIS DME ITEM HAS BEEN MET PER THE PROVIDER'S RENTAL TO PURCHASE AGREEMENT.
E12	RENTAL OF THIS ITEM IS NOT COVERED UNDER THE MEMBER'S BENEFIT PLAN.
E13	THIS CLAIM CANNOT BE PROCESSED UNTIL PRIMARY CARRIER PAYMENT INFORMATION IS RECEIVED.
E14	TAX AND/OR SHIPPING HAS BEEN COMBINED WITH DME ITEMS BILLED.
E15	NO SECONDARY PAYMENT PROVIDED DUE TO MEMBER'S ENROLLMENT IN THE EVERETT CLINIC PROGRAM. NO ACTION NECESSARY.
E16	NO SECONDARY PAYMENT PROVIDED DUE TO MEMBER'S ENROLLMENT IN THE SWEDISH HOME PROGRAM. NO ACTION NECESSARY.
E17	ADJUSTED TO COMPLY W PLAN NON-COVERAGE & MEMBER NON-LIABILITY RULES EFFECTIVE 1-2010. RULES ARE DOCUMENTED IN PROVIDER ADMIN POLICIES.
E18	SERVICE WAS NOT SUBMITTED ACCORDING TO CURRENT CDT NOMENCLATURE AND/OR DESCRIPTOR APPROVED BY THE AMERICAN DENTAL ASSOCIATION.
E19	PAID AT THE USUAL AND REASONABLE ALLOWED AMOUNT.
E20	SERVICES FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY ARE NOT COVERED BY THE PLAN.
E21	DIAGNOSIS ON THE CLAIM DOES NOT MATCH THE DIAGNOSIS ON THE PRESCRIPTION ON FILE.
E22	SERVICES BY A MASSAGE THERAPIST REQUIRE A PROVIDER PRESCRIPTION.
E23	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE DAILY FREQUENCY FOR THE PROCEDURE HAS BEEN EXCEEDED.
E25	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE DAILY FREQUENCY FOR THE PROCEDURE HAS BEEN EXCEEDED.
E26	CLAIM PREVIOUSLY PAID TO SERVICING PROVIDER. REMAINING BALANCE IS MEMBER LIABILITY.
E27	CLAIM PREVIOUSLY PAID TO SERVICING PROVIDER. REMAINING BALANCE IS MEMBER LIABILITY.

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EOP Message Codes

Code	Message
E90	NO PAYMENT PROVIDED. PATIENT IS A SWEDISH PROGRAM SELF-PAY MEMBER. NO ACTION NECESSARY.
E96	THIS CLAIM HAS BEEN ADJUSTED AS A RESULT OF A PROVIDER OVERPAYMENT AUDIT. NO FURTHER ACTION IS REQUIRED
F01	ADJUSTMENT DUE TO CHARGES BILLED IN ERROR.
F02	ADJUSTMENT DUE TO WRONG SUBSCRIBER CONTRACT BENEFIT APPLIED.
F03	ADJUSTMENT DUE TO WRONG SUBSCRIBER CONTRACT BENEFIT APPLIED.
F04	ADJUSTMENT DUE TO WRONG SUBSCRIBER CONTRACT BENEFIT APPLIED.
F06	ADJUSTMENT DUE TO COORDINATION OF BENEFITS WITH OTHER CARRIER.
F07	ADJUSTMENT DUE TO COORDINATION OF BENEFITS WITH OTHER CARRIER.
F08	ADJUSTMENT DUE TO DUPLICATE CLAIM PAID.
F09	ADJUSTMENT DUE TO DUPLICATE CLAIM PAID.
F10	ADJUSTMENT DUE TO DUPLICATE CLAIM PAID.
F11	ADJUSTMENT DUE TO RETROACTIVE CANCELLATION OF SUBSCRIBER AND/OR DEPENDENTS.
F12	WE RECEIVED YOUR CLAIM, WE REQUESTED ADDITIONAL INFORMATION FROM YOUR PROVIDER, WHEN WE RECEIVE THE INFORMATION WE WILL CONTINUE OUR REVIEW.
F13	WE RECEIVED YOUR CLAIM, WE REQUESTED ADDITIONAL INFORMATION FROM YOUR PROVIDER, WHEN WE RECEIVE THE INFORMATION WE WILL CONTINUE OUR REVIEW.
F15	WE HAVE RECEIVED YOUR CLAIM AND REQUESTED ADDITIONAL INFORMATION FROM YOU. ONCE THIS INFORMATION IS RECEIVED WE WILL CONTINUE OUR REVIEW.
F24	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM THAT RESULTED IN A REFUND.
F25	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM THAT RESULTED IN A REFUND
F26	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM THAT RESULTED IN A REFUND
F46	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM
F47	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM
F48	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM
F49	THIS IS A CLAIM ADJUSTMENT TO CORRECT A PREVIOUSLY PROCESSED CLAIM IN WHICH THE WRONG PROVIDER WAS PAID
F50	THIS IS A CLAIM ADJUSTMENT TO CORRECT A PREVIOUSLY PROCESSED CLAIM IN WHICH THE WRONG

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EOP Message Codes

Code	Message
	PROVIDER WAS PAID
F51	THIS IS A CLAIM ADJUSTMENT TO CORRECT A PREVIOUSLY PROCESSED CLAIM IN WHICH THE WRONG PROVIDER WAS PAID
F62	THE ALLOWABLE AMOUNT FOR THIS SERVICE WAS REDUCED ACCORDING TO MULTIPLE SAME-DAY SURGERY GUIDELINES.
F64	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
F65	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
F70	MAXIMUM BENEFITS HAVE BEEN PROVIDED FOR THIS CALENDAR YEAR.
F71	THE MEMBER IS OLDER THAN THE PLAN'S STUDENT AGE LIMIT ALLOWS
F72	THIS SERVICE IS NOT INCLUDED IN YOUR FEE SCHEDULE
F73	WE CAN'T PROCESS THIS CLAIM UNTIL THE INCIDENT QUESTIONNAIRE WE SENT THE MEMBER IS FULLY COMPLETED, SIGNED AND RETURNED.
F74	WORK-RELATED ILLNESS/INJURY BENEFITS MAY BE ELIGIBLE FOR WORKERS COMPENSATION (WC). PLEASE FILE WC AND CONTACT US IF BENES ARE DENIED.
F75	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN
F76	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM SUBSCRIBER
F77	MEDICAL RECORDS ARE REQUIRED TO PROCESS CLAIM
F78	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
F79	NO PATIENT PAYMENT DUE. THE PROVIDER SHOULD NOT BILL FOR ANY BALANCE DUE. REPORT ANY REQUEST FOR PAYMENT FROM THE PROVIDER.
F80	SERVICE NOT COVERED SINCE ILLNESS/INJURY OCCURRED PRIOR TO EFFECTIVE DATE
F81	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM SUBSCRIBER
F82	THIS CANNOT BE PROCESSED UNTIL CHARGES ARE FILED WITH OTHER INSURANCE
F83	THIS CANNOT BE PROCESSED UNTIL CHARGES ARE FILED WITH OTHER INSURANCE
F84	DUPLICATE LINE PREVIOUSLY PROCESSED
F85	BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
F86	BENEFITS NOT PROVIDED BECAUSE AN AUTO PIP OR MEDICAL PAYMENT POLICY IS PRIMARY. IF BENEFITS

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EOP Message Codes

Code	Message
	ARE DENIED OR EXHAUSTED, PLEASE RESUBMIT.
F87	THE SERVICES ARE NOT COVERED BECAUSE A THIRD PARTY HAS ACKNOWLEDGED RESPONSIBILITY.
F88	WE CAN'T PROCESS THIS CLAIM UNTIL THE INCIDENT QUESTIONNAIRE WE SENT THE MEMBER IS FULLY COMPLETED, SIGNED AND RETURNED.
F89	WORK-RELATED ILLNESS/INJURY BENEFITS MAY BE ELIGIBLE FOR WORKER'S COMPENSATION(WC). PLEASE FILE WC AND CONTACT US IF BENEFITS ARE DENIED
F91	CLAIMS RELATED TO A CLOSED WORKER'S COMPENSATION (WC), CLAIM MUST BE SUBMITTED TO WC FOR REOPENING. IF DENIED, RESUBMIT TO US.
F92	WE ARE UNABLE TO PROCESS THIS CLAIM UNTIL ADDITIONAL INCIDENT INFORMATION IS RECEIVED.
F93	WORKER'S COMPENSATION IS RESPONSIBLE FOR THESE SERVICES.
F94	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED
F95	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED
F96	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
F97	THIS CLAIM WAS PROCESSED UNDER YOUR PRIMARY COVERAGE AND WILL BE PROCESSED UNDER YOUR SECONDARY COVERAGE
F98	THE PLAN LIMITS BENEFITS FOR SEALANTS
F99	THE PLAN LIMITS BENEFITS FOR BITEWING X-RAYS
FA	AMOUNT HAS BEEN ADJUSTED BASED UPON YOUR FUNDING ACCOUNT
FA1	PATIENT LIABILITY ADJUSTED BASED UPON FUNDING ACCOUNT
FA2	THIS SERVICE QUALIFIED FOR REIMBURSEMENT FROM YOUR FUNDING ACCOUNT BUT ALL FUNDS HAVE BEEN EXHAUSTED.
FA3	OUR MEDICAL STAFF DETERMINED THIS PROCEDURE IS CONSIDERED COSMETIC. COSMETIC SERVICES ARE NOT COVERED BY YOUR MEDICAL PLAN OR FUND ACCOUNT
FB0	THIS CLAIM WAS ADJUSTED. CORRECTED INFORMATION IS SHOWN.
FB1	THIS AMOUNT REPRESENTS A NET OVERPAYMENT FROM YOUR ACCOUNT. OVERPAID AMOUNTS WILL BE AUTOMATICALLY DEDUCTED FROM FUTURE REIMBURSEMENTS.
FB2	NET REIMBURSEMENT WAS REDUCED TO OFFSET AN OVERPAYMENT ON A PRIOR CLAIM.
IAA	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THE SERVICE.
IAT	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THE SERVICE.

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EOP Message Codes

Code	Message
IAU	THIS CHARGE EXCEEDS THE MAXIMUM NUMBER OF UNITS ALLOWED FOR THIS SERVICE.
IAX	THIS IS A BLUECARD HOME CLAIM.
INH	DIFFERENCE BETWEEN THE BILLED CHARGE AND THE LOCAL PLAN'S ALLOWED AMOUNT IS MEMBER'S RESPONSIBILITY.
IPR	ITS PRIVATE ROOM NON-COVERED AMOUNT
ISS	THIS ISN'T A COVERED SERVICE FOR THIS MEMBER.
J02	THE PROCEDURE CODE WAS CROSSWALKED TO AN APPROPRIATE ANESTHESIA CODE.
J03	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE ANESTHESIA PROCEDURE CODE WAS PERFORMED BY A NON-ANESTHESIA PROVIDER
J04	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE MORE THAN ONE ANESTHESIA PROCEDURE CODE WAS BILLED ON THE SAME DOS
J05	A HISTORY CLAIM LINE IS DISALLOWED BECAUSE MORE THAN ONE ANESTHESIA PROCEDURE CODE WAS BILLED ON THE SAME DOS.
J06	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THERE IS A MISSING OR INVALID BEGINNING OR ENDING DATE OF SERVICE (DOS).
J08	THE PLACE OF SERVICE (POS) CODE IS MISSING OR INVALID.
J10	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS NOT TYPICAL FOR THE PATIENTS AGE.
J11	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE HAS BEEN DELETED.
J12	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS MISSING OR INVALID.
J13	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS NOT TYPICAL FOR THE PATIENTS GENDER.
J14	DOCUMENTATION IS REQUIRED WHEN A MODIFIER 59 IS BILLED WITH THE PROCEDURE CODE.
J15	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE IT IS A DUPLICATE OF ANOTHER CLAIM LINE.
J16	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PATIENTS DATE OF BIRTH IS MISSING, INVALID, OR AFTER THE DATE OF SERVICE.
J17	CLAIM LINE IS BEING DISALLOWED DUE TO THE NUMBER OF UNITS NOT MATCHING THE SPAN BETWEEN THE BEGINNING AND ENDING DATES OF SERVICE
J18	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE IT IS AN EXACT DUPLICATE OF A CLAIM IN HISTORY SUBMITTED BY THE SAME PROVIDER.

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EOP Message Codes

Code	Message
J20	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE AN E&M CODE IS WITHIN THE GLOBAL PERIOD WITH A SAME DIAGNOSIS CATEGORY BY THE SAME PROVIDER.
J22	CLAIM LINE IS DISALLOWED BECAUSE A SURGICAL CODE WAS SUBMITTED W/ IN THE GLOBAL PERIOD W/ A DX FROM SAME CATEGORY BY THE SAME PROVIDER.
J23	A HISTORY CLAIM LINE IS DISALLOWED BECAUSE ITS PROCEDURE CODE IS UNBUNDLED AND IS CONSIDERED EXCLUSIVE.
J24	A HISTORY CLAIM LINE IS DISALLOWED BECAUSE ITS PROCEDURE CODE IS UNBUNDLED AND IS CONSIDERED UNBUNDLED OR INCIDENTAL.
J26	A PROCEDURE CODE ON A HISTORY CLAIM LINE WAS PART OF A TRANSFER RELATIONSHIP, BUT THE PROCEDURE CODE WAS RETAINED.
J27	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE ONE OF THE DIAGNOSIS CODES IS NOT TYPICAL FOR THE PATIENTS AGE.
J28	A DIAGNOSIS CODE ON THE LINE IS NOT COMMONLY ASSOCIATED WITH THE PROCEDURE CODE.
J30	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THERE IS NO PRIMARY DIAGNOSIS CODE.
J32	THIS LINE IS BEING DISALLOWED BECAUSE THE DIAGNOSIS CODE REQUIRES A FOURTH AND/OR FIFTH DIGIT TO PROVIDE APPROPRIATE SPECIFICITY.
J33	THE CLAIM LINE CONTAINS AN INAPPROPRIATE MODIFIER COMBINATION.
J34	A MODIFIER ON THE LINE IS INVALID.
J35	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE A DIAGNOSIS CODE IS NOT TYPICAL FOR THE PATIENTS GENDER.
J36	THE PROCEDURE CODE REQUIRES A MODIFIER 26.
J37	CLAIM LINE IS BEING DISALLOWED BECAUSE MEDICARE TYPICALLY DOES NOT ALLOW REIMBURSEMENT FOR SURGICAL ASSISTANTS ON THIS PROCEDURE CODE
J39	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE HAS NO MEDICARE RELATIVE VALUE UNIT AND MAY BE CONSIDERED INCIDENTAL.
J40	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE SERVICE IS INCIDENTAL TO A PHYSICIAN SERVICE AND IS NOT SEPARATELY REIMBURSED BY MEDICARE.
J41	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE MEDICARE TYPICALLY DOES NOT ALLOW REIMBURSEMENT FOR CO-SURGEON ON THIS PROCEDURE CODE.
J42	MEDICARE REQUIRES THE PROCEDURE TO HAVE SUPPORTING DOCUMENTATION FOR AN ASSISTANT SURGEON.
J43	MEDICARE REQUIRES THE PROCEDURE TO HAVE SUPPORTING DOCUMENTATION FOR A CO-SURGEON.

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EOP Message Codes

Code	Message
J44	MEDICARE REQUIRES THE PROCEDURE TO HAVE SUPPORTING DOCUMENTATION FOR TEAM SURGERY
J45	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE DAILY FREQUENCY FOR THE PROCEDURE HAS BEEN EXCEEDED.
J47	THIS CLAIM LINE CONTAINS A MODIFIER THAT IS INAPPROPRIATE PER MEDICARE.
J48	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE INJECTION SERVICE IS BUNDLED INTO OTHER PAYABLE SERVICES WHEN BILLED ON THE SAME DOS.
J49	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE MEDICARE DEFINES THE SERVICE TO BE A NON-PHYSICIAN SERVICE
J50	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE SERVICES ARE NOT COVERED BY MEDICARE.
J51	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS NOT VALID FOR MEDICARE.
J52	A MODIFIER ON THE LINE IS NOT TYPICAL FOR THE PROCEDURE CODE.
J53	THIS LINE IS ELIGIBLE FOR A MULTIPLE PROCEDURE REDUCTION.
J54	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PHYSICAL THERAPY SERVICES ARE NOT COVERED BY MEDICARE.
J55	THIS CLAIM LINE IS DISALLOWED BECAUSE A SURGICAL CODE WAS SUBMITTED W/IN THE GLOBAL PERIOD W/ A DX FROM SAME CATEGORY BY SAME PROVIDER.
J56	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE TEAM SURGEONS ARE NOT PERMITTED WITH THIS PROCEDURE CODE PER MEDICARE.
J57	A HISTORY CLAIM LINE IS DISALLOWED BECAUSE ITS PROCEDURE CODE IS UNBUNDLED PER MEDICARE.
J58	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE ITS PROCEDURE CODE IS UNBUNDLED PER MEDICARE.
J59	A VENTILATION MANAGEMENT SERVICE WAS BILLED ON THE SAME DATE AS AN E&M SERVICE PER MEDICARE.
J60	A NON-PRIMARY DIAGNOSIS CODE WAS SUBMITTED AS THE PRIMARY DIAGNOSIS CODE.
J61	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE A NEW PATIENT E&M SERVICE WAS BILLED FOR AN ESTABLISHED PATIENT.
J62	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PATIENT ID IS MISSING OR INVALID.
J63	THE PROFESSIONAL COMPONENT MODIFIER 26 IS NOT APPROPRIATE WITH A 100% TECHNICAL PROCEDURE.
J64	THE PLACE OF SERVICE IS NOT TYPICAL FOR THE PROCEDURE CODE.
J65	THIS LINE IS ELIGIBLE FOR A ASSISTANT/CO/TEAM SURGERY MODIFIER REDUCTION.

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EOP Message Codes

Code	Message
J66	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PRE-OPERATIVE E&M WAS BILLED THE DAY BEFORE OR SAME DAY AS A SURGICAL PROCEDURE.
J67	A HISTORY LINE IS DISALLOWED BECAUSE A PRE-OPERATIVE E&M WAS BILLED THE DAY BEFORE OR SAME DAY AS A SURGICAL PROCEDURE IN HISTORY.
J68	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROVIDER ID IS MISSING OR INVALID.
J69	THE PATIENT GENDER IS MISSING OR INVALID.
J70	ORIGINAL BILLED PROCEDURE CODE(S) TRANSFERRED OR REBUNDLED PER INDUSTRY STANDARD GUIDELINES.
J71	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE ONLY ONE SURGICAL ASSISTANT IS ALLOWED PER PROCEDURE CODE.
J72	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE DOES NOT TYPICALLY ALLOW AN ASSISTANT SURGEON MODIFIER.
J73	THE SYSTEM TIMED OUT ON THIS CLAIM LINE.
J74	A DIAGNOSIS CODE ON THE LINE IS A POSSIBLE THIRD-PARTY LIABILITY.
J75	A TRANSFER TO AN APPROPRIATE PROCEDURE OCCURRED. THIS CLAIM LINES PROCEDURE WAS PART OF THE TRANSFER GROUP.
J76	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS UNBUNDLED AND IS CONSIDERED EXCLUSIVE.
J77	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS CONSIDERED UNBUNDLED.
J78	THE PROCEDURE CODE IS UNLISTED.
J79	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS CONSIDERED COSMETIC.
J80	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS CONSIDERED INVESTIGATIONAL OR EXPERIMENTAL.
J81	SUBMITTED UNITS EXCEED THE MANUFACTURER'S RECOMMENDED DOSAGE.
J82	SEPARATE REIMBURSEMENT FOR THIS SERVICE NOT PROVIDED.
J83	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE YEARLY FREQUENCY FOR THE PROCEDURE HAS BEEN EXCEEDED.
J84	PAYMENT FOR PROCEDURE CODE IS NOT ELIGIBLE FOR REIMBURSEMENT PER THE PLAN'S PAYMENT POLICY.
J85	ADD-ON PX CODE SUBMITTED WITHOUT APPROP PRIMARY PX CODE NOT ALLOWED.

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EOP Message Codes

Code	Message
J86	THE PRIMARY PROCEDURE RELATED TO THIS ADD-ON CODE PREVIOUSLY SUBMITTED WAS DENIED. THE ADD-ON CODE IS NOT ALLOWED.
J87	NON-COVERED PROCEDURE DISALLOWED.
J88	THE MAXIMUM FREQUENCY FOR THIS PROCEDURE HAS BEEN EXCEEDED.
J89	PLAN ALLOWS ONLY 1 E-VISIT PER 7 DAY PERIOD FOR THE SAME CONDITION, THE CLAIM IS DENIED.
J90	REIMBURSEMENT FOR STATE SUPPLIED VACCINE IS NOT ALLOWED.
J91	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS CONSIDERED INCIDENTAL.
MLN	PROVIDER: PLEASE SUBMIT THE PRIMARY DIAGNOSIS.
MSD	THE ALLOWABLE AMOUNT FOR THIS SERVICE WAS REDUCED ACCORDING TO MULTIPLE SAME-DAY SURGERY GUIDELINES.
MUT	OVERRIDE MEDICAL UTILIZATION EDITS
N01	THIS SERVICE'S ALLOWANCE IS INCLUDED IN ANOTHER SERVICE AND THEREFORE IS NOT COVERED.
N02	THIS SERVICE CANNOT BE PERFORMED IN THE SAME VISIT AS ANOTHER SERVICE AND THEREFORE IS NOT COVERED.
N03	THIS PROCEDURE IS CONSIDERED SECONDARY TO THE PRIMARY PROCEDURE.
N04	NORMAL BILLING PRACTICES COMBINE THE CHARGE FOR THIS VISIT WITH ANOTHER CHARGE. MAXIMUM BENEFITS WERE APPLIED TO THE COMBINED CHARGE.
N05	NORMAL BILLING PRACTICES COMBINE THE CHARGE FOR THIS VISIT WITH ANOTHER CHARGE. MAXIMUM BENEFITS WERE APPLIED TO THE COMBINED CHARGE.
N06	THIS PROCEDURE DOESN'T NORMALLY REQUIRE THE SERVICES OF AN ASSISTANT SURGEON.
N09	THIS PROCEDURE IS NORMALLY PERFORMED FOR COSMETIC PURPOSES, WHICH THE PLAN DOESN'T COVER.
N10	THE PLAN DOESN'T COVER THIS PROCEDURE BECAUSE IT'S CONSIDERED EXPERIMENTAL IN NATURE.
N11	THIS CLAIM LINE IS BEING DISALLOWED BECAUSE THE PROCEDURE CODE IS INVALID FOR DATE OF SERVICE.
N13	THE PLAN DOESN'T COVER THIS PROCEDURE.
N14	THE PROCEDURE CODE HAS BEEN CHANGED BASED ON THE PATIENT'S GENDER.
N15	THE PROCEDURE CODE HAS BEEN CHANGED BASED ON THE PATIENT'S AGE.
N16	THE PROCEDURE CODE HAS BEEN CHANGED BASED ON THE PATIENT'S AGE.

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EOP Message Codes

Code	Message
N17	THE PLAN DOESN'T COVER THIS SERVICE WHEN IT'S PERFORMED IN THIS SETTING.
N19	THE PLAN DOESN'T COVER THIS SERVICE WHEN IT'S PERFORMED FOR THE REPORTED DIAGNOSIS.
N25	NORMAL BILLING PRACTICES COMBINE THE CHARGE FOR THIS SERVICE WITH ANOTHER SERVICE. MAXIMUM BENEFITS WERE APPLIED TO THE COMBINED CHARGE.
N26	PRETREATMENT PROCEDURE DISALLOW
N27	INVALID MODIFIER DISALLOW
N29	CLINICAL DAILY MAXIMUM EXCEEDED
N30	LIFETIME MAXIMUM EXCEEDED
N41	THIS SERVICE'S ALLOWANCE IS INCLUDED IN ANOTHER SERVICE AND THEREFORE IS NOT COVERED.
N42	THIS SERVICE CANNOT BE PERFORMED IN THE SAME VISIT AS ANOTHER SERVICE AND THEREFORE IS NOT COVERED.
N43	A DELETED PROCEDURE CODE WAS REPLACED WITH A VALID PROCEDURE CODE.
N44	BASED ON THE SERVICES PERFORMED, A DIFFERENT MEDICAL CODE WAS USED TO APPLY BENEFITS.
N45	DUE TO A NEW PATIENT VISIT CHARGE WITHIN THE PAST THREE YEARS, THIS WAS REPLACED WITH AN ESTABLISHED VISIT CODE.
N50	CURRENT PROCEDURE REBUNDLE
N51	HISTORY PROCEDURE REBUNDLE
N52	DUPLICATE UNI OR BILATERAL PROCEDURE
N53	DUP HISTORY UNI OR BILATERAL PROCEDURE
N54	MAX LIFETIME OCCURRENCE
N55	HISTORY MAX LIFETIME OCCURRENCE-
N56	DUPLICATE PROCEDURE SUBMITTED
N57	HISTORY DUP PROCEDURE SUBMITTED
N58	MUTUALLY EXCLUSIVE PROCEDURE
N59	HISTORY INCIDENTAL PROCEDURE
N60	ASSISTANT SURGEON SOMETIMES REQUIRED
N61	AGE CONFLICT REPLACED PROCEDURE

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EOP Message Codes

Code	Message
N62	GENDER CONFLICT REPLACED PROCEDURE
N63	HISTORY PROCEDURE ADDED LINE REBUNDLE
N64	PREOP CONFLICT WITHIN 1 DAY
N65	HISTORY POSTOP CONFLICT WITHIN 90 DAYS
N66	HISTORY MEDICAL VISIT CONFLICT
N67	NEW PT VISIT CONFLICT PROCEDURE
N68	INTENSITY OF SERVICE CONFLICT
N69	DUPLICATE COMPONENT BILLING CONFLICT CURRENT OR HISTORY
N71	MULTIPLE COMPONENT BILLING CONFLICT
N73	THIRD PARTY LIABILITY POTENTIAL
N76	INVALID PROCEDURE MODIFIER COMBINATION
N77	INVALID MODIFIER
N78	INVALID DIAGNOSIS CODE
N79	UNITS EXPANSION FAILED
O25	CHARGES COMBD DUE TO DENT CLIN EDIT
OAS	THE PLAN DOESN'T NORMALLY COVER THIS SERVICE FOR MEMBERS IN THIS AGE RANGE.
OOA	WE PROCESSED THIS CLAIM USING THE OUT-OF-NETWORK PROVIDER LEVEL OF BENEFITS.
OPC	OVERRIDE PCA DISALLOW.
OUT	RISK-SHARE CALCULATION APPLIED-PROVIDER LIABILITY
P02	VISIT CONSISTS OF ALL NEVER PAY OR STAND ALONE
P03	SERVICE IS NEVER PAY
P05	SERVICE IS CARVE OUT
P50	PRESENT ON ADMISSION INDICATOR REQUIRED BUT IS NOT VALID.
PAA	THIS CHARGE EXCEEDS THE CONTRACTED AMOUNT FOR THIS SERVICE.
PAC	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PAH	APC RATE

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EOP Message Codes

Code	Message
PAI	THE CHARGES EXCEED THE CONTRACTED AMOUNT FOR THIS SERVICE.
PAK	THE CHARGES EXCEED THE CONTRACTED AMOUNT FOR THIS SERVICE.
PAL	THE CHARGES EXCEED THE CONTRACTED RATE FOR THIS SERVICE.
PAP	THE CHARGES EXCEED THE CONTRACTED RATE FOR THIS SERVICE.
PAR	THE CHARGE EXCEEDS THE CONTRACTED AMOUNT FOR THIS SERVICE.
PBA	WE PROCESSED THIS CLAIM WITH BENEFITS IN EFFECT ON THE ADMISSION DATE.
PBM	WE APPLIED MAJOR MEDICAL BENEFITS TO THIS CLAIM.
PCD	THE PROVIDER'S CONTRACT DOESN'T ALLOW THIS SERVICE.
PDA	THE CHARGE WAS REDUCED BASED ON A DISCOUNT ARRANGEMENT WITH THE PROVIDER.
PDC	THE CHARGE WAS REDUCED BASED ON A DISCOUNT ARRANGEMENT WITH THE PROVIDER.
PDD	THE CHARGE WAS REDUCED BASED ON A DISCOUNT ARRANGEMENT WITH THE PROVIDER.
PDP	THE CHARGE WAS REDUCED BASED ON A DISCOUNT ARRANGEMENT WITH THE PROVIDER.
PE0	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PEO	THE CHARGE EXCEEDS THE CONTRACTED AMOUNT FOR THIS SERVICE.
PEX	THE CHARGES EXCEED THE PROVIDER'S SCHEDULED RATE.
PFC	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PFS	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PFU	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THE SERVICE.
PFV	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PFW	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PGA	THE CHARGE EXCEEDS THE DRG-ALLOWED AMOUNT FOR THIS HOSPITAL STAY.
PGD	THE CHARGE EXCEEDS THE DRG-ALLOWED AMOUNT FOR THIS HOSPITAL STAY.
PGE	THE CHARGE EXCEEDS THE DRG-ALLOWED AMOUNT FOR THIS HOSPITAL STAY.
PGO	THE CHARGE EXCEEDS THE DRG-ALLOWED AMOUNT FOR THIS HOSPITAL STAY.
PGP	THE CHARGE EXCEEDS THE DRG-ALLOWED AMOUNT FOR THIS HOSPITAL STAY.

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EOP Message Codes

Code	Message
PGR	THE CHARGE EXCEEDS THE DRG-ALLOWED AMOUNT FOR THIS HOSPITAL STAY.
PIM	ITS MEDICARE PRICING DISALLOW
PLA	THE CHARGE EXCEEDS THE ALLOWED AMOUNT FOR THIS HOSPITAL STAY.
PLC	THE MEDICARE LIMITING CHARGE WAS APPLIED.
PLP	THE PERCENT THRESHOLD STOPLOSS WAS MET.
PLT	THE MEMBER'S OUT OF POCKET MAXIMUM WAS MET.
PMI	PROCEDURE MODIFIER COMBINATION INVALID.
PMP	PRICE ADJUSTED DUE TO ADDITIONAL LINE ITEM MODIFIERS.
PMX	MAXIMUM PROVISION
PPA	PACKAGED APC LINE
PPC	THIS CHARGE EXCEEDS THE AMBULATORY PAYMENT CLASSIFICATION (APC) RATE.
PPG	Exceeds APG rate for the line item
PS	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THE SERVICE.
PS0	THE PLAN DOESN'T COVER THIS SERVICE.
PS1	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PS2	THIS CHARGE EXCEEDS THE MAXIMUM NUMBER OF UNITS ALLOWED FOR THIS SERVICE.
PSB	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
PSC	THE CHARGE EXCEEDS THE USUAL AND CUSTOMARY AMOUNT FOR THIS PROCEDURE.
PSM	THE CHARGE EXCEEDS THE ALLOWABLE RATE FOR THIS SERVICE.
PSN	CHARGE EXCEEDS SNF AMOUNT FOR SERVICES.
PSR	THE CHARGE EXCEEDS THE ALLOWABLE RATE FOR THIS SERVICE.
PSS	THE CHARGE EXCEEDS THE ALLOWABLE RATE FOR THIS SERVICE.
PSU	THE CHARGE EXCEEDS THE ALLOWABLE RATE FOR THIS SERVICE.
PSV	THE CHARGE EXCEEDS THE ALLOWABLE RATE FOR THIS SERVICE.
PSW	THE CHARGE EXCEEDS THE ALLOWABLE RATE FOR THIS SERVICE.

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EOP Message Codes

Code	Message
PTR	CHARGES EXCEED THE FEE SCHEDULE MAXIMUM ALLOWABLE AMOUNT.
PX1	PRICING WILL BE MANUALLY CALCULATED AND ENTERED
PX2	PRICING IS COST.
PX3	PRICING IS COST PLUS 10% OF THE COST
PX4	PRICING=COST + 999.99% OF COST. IF COST NOT SUBMITTED, PRICING=CHGS
PX5	IF COST EXCEEDS $300.00, PRICING IS COST PLUS 10% OF THE COST.
PX6	COST + PCT W/THRESHOLD OR NOT COST CHG
PX7	PRICING IS COST. IF NO COST IS SUBMITTED, PRICING IS CHARGE
PX8	IF THE COST EXCEEDS $1,000.00, PRICING IS COST
PX9	DISCOUNT EXCESS DAYS
PXA	DISCOUNT + PER DIEM
PXB	ASC GROUPER, 8 LV
PXC	ASC GROUPER, EXCEPTION AMOUNT
PXD	ASC GROUPER, EXCEPTION AMOUNT & PERCENT
PXE	ASC GROUPER, EXCEPT AMOUNT & PERCENT WITH MAX
PXF	ASC GROUPER, EXCEPTION PCT
PXG	ASC GROUPER, EXCEPTION PERCENT W/MAX
PXH	ASC GROUPER, 9LV
PXI	ASC GROUPER, 10 LV
PXJ	ANESTHESIA SCHEDULE
PXK	ANESTHESIA SCHEDULE, 2 LVL TIME
PXL	APC W/BASE RATE
PXM	ASC EXCEPT AMOUNT & PERCENT W/ PROC MAX
PXN	PRICED PER ALLOWED AMOUNT
PXO	SERVICE + COST LESS PERCENTAGE

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EOP Message Codes

Code	Message
PXP	SERVICE + COST PLUS PCT
PXV	DENTAL FEE SCHEDULE
Q00	COMMERCIAL AIR TRAVEL FOR THIS SERVICE IS ONLY COVERED FOR THE PATIENT
Q01	COMMERCIAL AIR TRAVEL FOR THIS SERVICE IS ONLY COVERED ONE WAY TO THE NEAREST FACILITY.
Q02	COMMERCIAL AIR TRAVEL IS ONLY COVERED WHEN TRAVELING TO SEATTLE, WA. FOR A COVERED MEDICAL SERVICE.
Q03	COMMERCIAL AIR TRAVEL IS NOT COVERED FOR THIS CONDITION.
Q04	COMMERCIAL AIR TRAVEL IS ONLY COVERED FOR ONE WAY TRAVEL FOR THE PATIENT ONLY.
Q05	COMMERCIAL AIR TRAVEL IS ONLY COVERED FOR SUDDEN LIFE ENDANGERING ILLNESS OR ACCIDENT. THE MEMBER MUST BE ADMITTED AS INPATIENT.
Q06	COMMERCIAL AIR TRAVEL IS ONLY COVERED WITH AN MD-CERTIFIED STATEMENT THAT THE SVC IS MED NECESSARY AND NOT AVAIL AT A CLOSER FACILITY.
Q07	THIS CLAIM IS BEING PAID WHILE WE ARE RESEARCHING COB.
Q09	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED. ADDITIONAL MONITORS WILL NEED TO BE REVIEWED FOR MEDICAL NECESSITY.
Q11	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
Q14	NITROUS OXIDE COVERED ONLY WHEN ADMINISTERED IN CONNECTION WITH CLASS II OR CLASS III DENTAL SERVICES.
Q15	PROVIDER: YOUR MULTIPLE PER CASE/PER DIEM CALCULATION WAS APPLIED TO THIS CLAIM.
Q16	AN AUTO PIP OR MEDICAL PAYMENT POLICY IS PRIMARY. WE ARE PAYING THE COVERED BALANCE AFTER PIP WAS EXHAUSTED.
Q17	AN AUTO PIP OR MEDICAL PAYMENT POLICY IS PRIMARY. WE ARE PAYING THE COVERED BALANCE AFTER PIP WAS EXHAUSTED.
Q18	THE PLAN DOESN'T COVER THIS SERVICE.
Q22	THE MEMBER'S PLAN PAYMENT MAXIMUM WAS MET.
Q24	WE'VE COORDINATED THIS CLAIM WITH YOUR PRIMARY INSURANCE PLAN.
Q29	THE MEMBER'S OUT OF POCKET MAXIMUM WAS MET.
Q30	BASED ON THE OFFICE RECORDS, A MORE APPROPRIATE CODE WAS USED TO ADMINISTER DENTAL BENEFITS.

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EOP Message Codes

Code	Message
Q31	NIGHTGUARDS ARE COVERED FOR THE TREATMENT OF BRUXISM, BUT NOT MORE OFTEN THAN ONCE IN ANY FIVE-YEAR PERIOD.
Q33	PERIODONTAL ROOT SCALING AND ROOT PLANING LIMITED TO ONCE PER QUADRANT OF THE MOUTH IN ANY SIX-CONSECUTIVE MONTH PERIOD.
Q34	THE MEMBER IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN BILLED CHARGES AND ALLOWED CHARGES.
Q37	THIS IS YOUR COINSURANCE AMOUNT.
Q38	THIS IS YOUR DEDUCTIBLE AMOUNT.
Q41	INAPPROPRIATE USE OF MODIFIER, PLEASE REBILL.
Q47	VISION EXAM AND TEST LIMIT MET. 1 ALLOWED PER EVERY 2 CALENDAR YEARS.
Q48	BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
Q50	DENTAL ACCIDENT BENEFITS AREN'T AVAILABLE SINCE THE TOOTH WASN'T A SOUND AND NATURAL TOOTH BEFORE THE ACCIDENT.
Q51	THE MAXIMUM COINSURANCE-ALLOWABLE CHARGES HAVE BEEN MET.
Q52	THIS PLAN COVERS PERIODONTAL MAINTENANCE ONCE IN A 3 MONTH PERIOD.
Q53	VISION HARDWARE LIMIT HAS BEEN MET. 2 LENS PER CALENDAR YEAR OR 1 FRAME EVERY 2 CONSECUTIVE CALENDAR YEARS.
Q54	DENTAL ACCIDENT BENEFITS AREN'T AVAILABLE BECAUSE IT'S BEEN MORE THAN 12 MONTHS SINCE THE ACCIDENT THAT CAUSED THE INJURY.
Q55	THE MAXIMUM BENEFIT FOR THIS TYPE OF SERVICE HAS BEEN USED, SO NO FURTHER COVERAGE IS AVAILABLE FOR THIS SERVICE.
Q56	THIS CLAIM WAS COORDINATED BASED ON INFORMATION SUBMITTED. ON FUTURE CLAIMS PLEASE SUBMIT THE OTHER CARRIER'S EXPLANATION OF BENEFITS.
Q57	THIS IS NOT A CURRENT ADA/CPT CODE. THE ALLOWED CODE REFLECTS THE CURRENT ADA/CPT CODE.
Q62	THE AMOUNT PREVIOUSLY ALLOWED FOR THE AMALGAM/COMPOSITE RESTORATION HAS BEEN DEDUCTED FROM THIS PROCEDURE.
Q63	THIS CLAIM IS DENIED BECAUSE THE TIME LIMIT FOR FILING HAS EXPIRED.
Q65	THE FAMILY COINSURANCE ALLOWABLE HAVE BEEN MET.
Q66	THE MEDICAL DEDUCTIBLE WAS APPLIED TO THIS SERVICE.
Q68	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.

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EOP Message Codes

Code	Message
Q69	THIS SERVICE IS NOT A COVERED MEDICAL SERVICE. PLEASE SUBMIT TO A VISION VENDOR.
Q70	THE LIFETIME ORTHODONTIC DEDUCTIBLE WAS APPLIED TO THIS SERVICE.
Q71	THE LIFETIME ORTHODONTIC DEDUCTIBLE WAS APPLIED TO THIS SERVICE.
Q73	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
Q74	OUR DENTAL CONSULTANT HAS REVIEWED THIS CLAIM AND HAS DETERMINED THAT THIS SERVICE IS COSMETIC. THIS PLAN DOES NOT COVER COSMETIC SERVICES.
Q75	THIS PROVIDER IS PART OF THE PHCS NETWORK AND PHCS DISCOUNT PRICING HAS BEEN APPLIED.
Q76	THIS PROVIDER IS PART OF THE PHCS NETWORK AND PHCS DISCOUNT PRICING HAS BEEN APPLIED
Q80	RENTAL CHARGE EXCEEDS PURCHASE PRICE OF THE DURABLE MEDICAL EQUIPMENT OR COST FOR PURCHASE HAS BEEN PAID ON A PRIOR CLAIM.
Q81	THE PLAN DOESN'T PROVIDE DEPENDENT COVERAGE FOR THESE SERVICES.
Q82	THE PLAN PROVIDES SUBSCRIBER ONLY COVERAGE FOR THESE SERVICES.
Q84	THE PLAN PROVIDES SPOUSE ONLY COVERAGE FOR THESE SERVICES.
Q85	THE PLAN PROVIDES DEPENDENT ONLY COVERAGE FOR THESE SERVICES
Q86	THE PLAN DOESN'T PROVIDE SPOUSE COVERAGE FOR THESE SERVICES.
Q87	THE PLAN DOESN'T PROVIDE SUBSCRIBER COVERAGE FOR THESE SERVICES.
Q88	THIS CHARGE WAS REDUCED DUE TO A DISCOUNT ARRANGEMENT WITH THE PROVIDER.
Q89	SERVICES BY THIS PROVIDER ARE NOT COVERED AS DEFINED UNDER THE TERMS OF YOUR CONTRACT.
Q90	THE ANNUAL MAXIMUM HAS BEEN REACHED WITH THIS SERVICE.
Q91	HYGIENIST SERVICES ARE NOT COVERED UNLESS BILLED AND SUPERVISED BY A DENTIST.
Q92	PROCEDURE EXCLUSIVE TO OUTPATIENT FACILITY PPS REIMBURSEMENT
Q93	SPECIAL ADOPTIVE CHILD PROCESS
Q95	THE $500 PREVENTATIVE CALENDAR YEAR BENEFIT HAS BEEN MET.
Q97	UNABLE TO PROCESS INVALID OR DELETED PROCEDURE CODE, PLEASE CONTACT YOUR PROVIDER.
Q98	PLEASE RESUBMIT FOR PAYMENT WHEN THIS DENTAL PROSTHETIC HAS BEEN SEATED OR DELIVERED.
RWD	CHARGES EXCEED THE FEE SCHEDULE MAXIMUM ALLOWABLE AMOUNT.

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EOP Message Codes

Code	Message
S10	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S11	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S12	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S13	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S14	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S17	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S1A	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S1B	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S1C	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S1D	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S1E	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S1F	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S2	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S20	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S21	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S22	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S23	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S24	PART A OR PART B OF MEDICARE ISN'T ACTIVE FOR THIS MEMBER.
S3	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
S5	MEMBER NOT ELIGIBLE FOR PRODUCT CATEGORY
S6	THE MEMBER'S AGE EXCEEDS THE PLAN'S AGE LIMIT.
S7	THE MEMBER'S AGE EXCEEDS THE PLAN'S AGE LIMIT.
S8	THE MEMBER'S AGE EXCEEDS THE PLAN'S AGE LIMIT.
S9	THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
SB	THE PATIENT ISN'T A COVERED MEMBER UNDER THE PLAN.
SC	THE PATIENT ISN'T A COVERED MEMBER UNDER THE PLAN.

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EOP Message Codes

Code	Message
SD	THE PATIENT ISN'T A COVERED MEMBER UNDER THE PLAN.
SE	THE PATIENT ISN'T A COVERED MEMBER UNDER THE PLAN.
SF	THE PATIENT ISN'T A COVERED MEMBER UNDER THE PLAN.
SG	THE PATIENT ISN'T A COVERED MEMBER UNDER THE PLAN.
SL	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SM	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SN	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SO	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SP	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SPD	THE ALLOWED CHARGES HAVE BEEN REDUCED DUE TO A SUPPLEMENTAL DISCOUNT.
SQ	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SS	THE PLAN DIDN'T COVER THE MEMBER ON THE DATE OF SERVICE.
ST	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
SW	THE MEMBER ISN'T ELIGIBLE FOR BENEFITS.
TBD	ITS PRIVATE ROOM NON-COVERED AMOUNT
TF0	THIS CLAIM WAS RECEIVED BEYOND THE PLAN'S TIMELY FILING LIMIT.
TF1	THIS CLAIM WAS RECEIVED BEYOND THE TIMELY FILING LIMIT.
TR0	THE PLAN DOESN'T COVER THIS SERVICE.
TR1	THE PLAN DOESN'T COVER THIS SERVICE.
TR2	THE CHARGE EXCEEDS THE COVERED AMOUNT FOR THE SERVICE.
TR3	THE COVERED AMOUNT IS GREATER THAN THE SERVICE'S ALLOWED AMOUNT PLUS THE RELATED HISTORY AMOUNT.
TR4	THE COVERED AMOUNT IS GREATER THAN THE SERVICE'S ALLOWED AMOUNT.
TR5	YOUR BENEFIT LIMITS HAVE BEEN MET ON THIS SERVICE.
TR6	THE PAYMENT IS REDUCED BY THE AMOUNT PAID BY ANOTHER INSURANCE PLAN.
UAS	THE PLAN DIDN'T COVER THE MEMBER ON THE DATE THE SERVICE WAS PROVIDED.

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EOP Message Codes

Code	Message
UD	THE AMOUNT WAS DISALLOWED BY UTILIZATION MANAGEMENT.
UED	THIS DENTAL PROCEDURE WAS DISALLOWED.
UM0	THE SERVICES WERE DISALLOWED BY CARE FACILITATION.
UM1	THE UNITS EXCEED A CARE FACILITATION AUTHORIZATION.
UM2	THE UNITS WERE REDUCED BY A CARE FACILITATION AUTHORIZATION.
UM4	CALENDAR YEAR WARNING APPLIED
V03	SAVINGS RESULTING FROM THE REDUCTION OF BENEFITS UNDER CONTRACTS BECAUSE OF MEDICARE
V05	MEMBER HELD HARMLESS FOR DIFFERENCE BETWEEN THE ALLOWED AMOUNT AND BILLED CHARGES.
V06	SAVINGS RESULTING FROM DIFFERENCE BETWEEN NEGOTIATED PRICING WITH PROVIDER AND AMOUNT BILLED ON THE CLAIM.
V07	NET DOLLAR SAVINGS RESULTING WHEN WORKER'S COMPENSATION LIABILITY IS DETERMINED
V08	NET DOLLAR SAVINGS FROM RECOVERY OF PLAN PAYMENTS FOR SUBSCRIBERS WHOSE PERSONAL INJURY WERE REIMBURSED BY OUTSIDE INSURANCE SOURCE.
V09	NET DOLLAR SAVINGS RESULTING WHEN NO FAULT LIABILITY IS DETERMINED.
V10	AMOUNT OF OTHER CARRIER PAYMENT APPLIED TO THE CLAIM TO REDUCE THE BCBS LIABILITY AMOUNT.
V11	REDUCTION IN BENEFITS LEVIED AGAINST SUBSCRIBER FROM VOLUNTARY USE OF PROVIDER OTHER THAN POS NETWORK OR REFERRED.
V13	THE REDUCTION IS THE DIFFERENCE BETWEEN THE BILLED CHARGES FOR COVERED SERVICES AND THE ALLOWANCE ON PROFESSIONAL CLAIMS.
V14	SAVINGS FROM ARRANGEMENTS BETWEEN PLAN AND INSTITUTIONAL PROVIDER TO REIMBURSE ON OTHER THAN A 100 PERCENT BASIS
V15	SAVINGS FROM ARRANGEMENTS BETWEEN PLAN AND INSTITUTIONAL PROVIDER TO REIMBURSE ON OTHER THAN A 100 PERCENT BASIS
V16	REDUCTION FROM BILLED CHARGES FOR SERVICES CONSIDERED IN EXCESS OF LEVEL OF CARE REQUIRED.
V17	REDUCTION FROM BILLED CHARGES FOR SERVICES CONSIDERED NOT MEDICALLY NECESSARY DUE TO UTILIZATION REVIEW. SUBSCRIBER IS HELD HARMLESS.
V18	REDUCTION IN BENEFITS IS AMOUNT LEVIED AGAINST SUBSCRIBER FOR NONCOMPLIANCE W/ PREADMISSION REVIEW REQUIREMENTS.
V19	REDUCTION IN BENEFITS IS AMOUNT LEVIED AGAINST SUBSCRIBERS FOR NONCOMPLIANCE W/CONTRACT

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EOP Message Codes

Code	Message
	REQUIREMENTS.
V20	REDUCTION IN BENEFITS IS AMOUNT LEVIED AGAINST SUBSCRIBERS FOR NONCOMPLIANCE W/RECOMMNDTINS TO THE SITE CONSIDRD APPRO FOR PROCD
V21	AMOUNT WHICH REIMBURSEMENT TO PROVIDER IS LESS THAN THE AMOUNT OF BILLED CHARGES
V24	REDUCTION IN BENEFITS IS AMOUNT LEVIED AGAINST SUBSCRIBERS FOR NONCOMPLIANCE WITH RECOMMENDATIONS
V27	COORDINATING TO OTHER CARRIER'S PRICE/ALLOWABLE WHEN PAYING CLAIM AS SECONDARY, AN ACCESS FEE NOT ALLOWED
V29	DOLLAR AMOUNT THAT IS ADDED TO THE SUBSCRIBER LIABILITY AS A RESULT OF APPLYING PAYMENT MAXIMUM.
V31	REDUCTION IN BENEFITS AGAINST SUBSCRIBERS FOR VOLUNTARY USE OF PROVIDER OTHER THAN AN AVAILABLE PREFERRED PROV W/IN SVC AREA
V35	WEEKEND ADMISSION NOT ELIGIBLE FOR FULL CONTRACT BENEFITS EXCEPT WHEN SPECIFIED CONDITIONS ARE MET
V37	REDUCTION IN BENEFITS IS THE AMOUNT AGAINST SUBSCRIBERS ACCORD W/CONTRACT FOR NONCOMPLIANCE WITH ADMIN REVIEW
V46	THIS CLAIM WAS SUBMITTED WITH INCORRECT MEMBER ID. THE LOCAL BC/BS PLAN WILL RESUBMIT THIS CLAIM WITH YOUR NEW ALPHA PREFIX AND MEMBER ID
V47	PROCESSED THROUGH THE BLUECARD PROGRAM FOR OUT-OF-AREA SERVICES.
V48	THE PLAN DOESN'T COVER THIS SERVICE.
V49	THIS CLAIM WAS SUBMITTED WITH INCORRECT MEMBER ID. THE LOCAL BC/BS PLAN WILL RESUBMIT THIS CLAIM WITH YOUR NEW ALPHA PREFIX AND MEMBER ID
VBB	VBB BYPASS EXPLANATION #1.
W01	BENEFITS WERE PREDETERMINED FOR THE LIFETIME ORTHO MAXIMUM. PLEASE CHECK YOUR BENEFIT BOOKLET FOR SPECIFIC ORTHO DEDUCTIBLE/PLAN LIMITS.
W03	BASED ON INFORMATION PROVIDED, ONLY ONE EXAM IS ALLOWED WHEN BILLED ON THE SAME DAY.
W07	THE MAXIMUM BENEFITS FOR THIS SERVICE HAVE BEEN PROVIDED.
W08	ORTHODONTIA BENEFIT CALENDAR YEAR LIMIT HAS BEEN MET.
W09	YOUR TRANSPLANT BENEFIT HAS BEEN MET BASED ON BDCT AGREEMENT PROVIDER WRITE-OFF.
W10	TO PAY THIS CLAIM WE NEEDED TO REVIEW INFORMATION FROM THE PROVIDER. WE HAVEN'T RECEIVED THE INFORMATION.

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EOP Message Codes

Code	Message
W11	WE CAN'T PROCESS THIS CLAIM BECAUSE WE HAVEN'T RECEIVED YOUR RESPONSE TO OUR REQUEST FOR ADDITIONAL INFORMATION.
W15	THIS SERVICE IS NOT PAID SEPARATELY, IT IS INCLUDED IN THE PAYMENT FOR THE FACILITY CHARGES.
W16	PAYMENT IS BASED ON CO-SURGEON GUIDELINES
W17	OUR MEDICAL STAFF REVIEWED AND DETERMINED THAT THE OBESITY PROGRAM WAS NOT COMPLETED
W18	SOME OF THE CHARGES ON THIS ORIGINAL CLAIM ARE BEING PROCESSED ON ANOTHER CLAIM.
W19	THIS IS A CLAIM ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM.
W20	THIS IS A CLAIM ADJUSTMENT TO CORRECT A PREVIOUSLY PROCESSED CLAIM IN WHICH THE WRONG PROVIDER WAS PAID.
W21	THE CHARGES ON THIS FOREIGN CLAIM HAVE BEEN CONVERTED TO U.S. DOLLARS AT THE RATE IN EFFECT ON THE DATE OF SERVICE.
W22	WE CAN'T PROCESS THIS CLAIM BECAUSE WE HAVEN'T RECEIVED THE NECESSARY INFORMATION WE REQUESTED FROM YOUR PROVIDER.
W23	WE CAN'T PROCESS THIS CLAIM BECAUSE WE HAVEN'T RECEIVED YOUR RESPONSE TO OUR REQUEST FOR INFORMATION.
W24	OUR MEDICAL STAFF REQUESTED AND RECEIVED INFORMATION ON THIS CLAIM, BUT THE INFORMATION PROVIDED WAS INCOMPLETE.
W25	PROVIDER: PLEASE SEND US THE MEMBER'S MEDICAL RECORDS FOR THIS CLAIM. WE CAN PROCESS THE CLAIM AFTER WE RECEIVE THAT INFORMATION.
W26	THESE CHARGES WERE PREVIOUSLY PAID ON FACILITY'S FINAL BILL.
W27	WE'VE COORDINATED THIS CLAIM WITH YOUR PRIMARY INSURANCE PLAN.
W28	THE INITIAL DIAGNOSTIC VISIT FOR THIS CONDITION IS COVERED. HOWEVER, SUBSEQUENT VISITS FOR TREATMENT ARE EXCLUDED AND WILL NOT BE COVERED.
W32	ACCORDING TO OUR RECORDS, THIS MEMBER DOES NOT HAVE DENTAL BENEFITS UNDER THIS CONTRACT.
W33	THIS IS AN ADJUSTMENT OF A PREVIOUSLY PROCESSED CLAIM THAT RESULTED IN A REFUND.
W34	MEMBER LIABILITY MAY NOT REFLECT PRIMARY CARRIER PAYMENT. YOUR PRIMARY CARRIER EOB FOR MORE DETAIL.
W35	THIS PROVIDER ISN'T ELIGIBLE AS DEFINED UNDER THE TERMS OF THE PLAN.
W36	CLAIM IS DENIED BECAUSE THE PRIMARY CARRIER'S GUIDELINES WERE NOT FOLLOWED.

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EOP Message Codes

Code	Message
W37	CLAIM IS DENIED BECAUSE THE PRIMARY CARRIER'S GUIDELINES WERE NOT FOLLOWED.
W38	THIS CLAIM HAS BEEN SENT TO THE LOCAL BLUE CROSS BLUE SHIELD PLAN PER THE BLUECARD PROGRAM. A NEW EOB WILL BE RECEIVED WHEN COMPLETED.
W39	EMERGENCY AND OTHER NON-ROUTINE SERVICES ARE LIMITED TO 1 PER CALENDAR YEAR
W40	PERIDONTAL MAINTENANCE IS LIMITED TO 2 VISITS PER CALENDAR YEAR.
W41	THE PLAN LIMITS BENEFITS FOR LIMITED OCCLUSAL ADJUSTMENTS
W42	DONOR CLAIM PROCESSED UNDER THE RECIPIENT'S ELIGIBILITY
W43	DONOR COSTS FOR ORGAN OR BONE MARROW TRANSPLANTS ARE NOT COVERED WHEN THE DONOR IS AN ENROLLEE BUT THE RECIPIENT IS NOT.
W44	MISROUTED-CLAIMS FOR THESE SERVICES NEED TO BE SUBMITTED TO: MHN PO BOX 14621, LEXINGTON, KY 40512-4621
W45	CLAIM IS DENIED BECAUSE THE PRIMARY CARRIER'S GUIDELINES WERE NOT FOLLOWED.
W46	THE PLAN PROVIDES SUBSCRIBER AND SPOUSE COVERAGE ONLY.
W47	CLAIM CLOSED UNTIL REQUESTED INFORMATION IS RECEIVED FROM THE PROVIDER
W48	CLAIM FOR NON-NETWORK PROVIDER PAID AT IN-NETWORK LEVEL. TO RECEIVE IN-NETWORK BENEFIT LEVEL FOR FUTURE SERVICES, USE IN-NETWORK PROVIDER.
W49	THIS CLAIM HAS BEEN COORDINATED WITH YOUR OTHER CARRIER.
W50	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
W51	ROUTINE ORAL EXAMINATIONS ARE LIMITED. YOU HAVE MET THE LIMIT FOR YOUR CONTRACT OR POLICY.
W54	THIS CLAIM HAS BEEN PROCESSED UNDER YOUR STANDARD MILLIMAN USA COVERAGE. IT WILL ALSO BE PROCESSED UNDER YOUR MERP COVERAGE.
W55	A MERP CLAIM WILL NOT BE PROCESSED SINCE YOUR MILLIMAN USA COVERAGE HAS PAID THIS CLAIM IN FULL.
W56	A MERP CLAIM WILL NOT BE PROCESSED SINCE YOUR MAXIMUM MERP BENEFITS HAVE PREVIOUSLY BEEN PAID.
W57	THIS CLAIM WAS PROCESSED UNDER YOUR MERP COVERAGE. THE OTHER COVERAGE FIELD REPRESENTS THE AMOUNT PAID BY YOUR MILLIMAN USA COVERAGE.
W58	THIS CLAIM HAS BEEN COORDINATED WITH YOUR OTHER CARRIER AND IT WILL ALSO BE PROCESSED UNDER YOUR MERP COVERAGE.
W59	A MERP CLAIM WILL NOT BE PROCESSED SINCE YOUR MILLIMAN USA COVERAGE AND/OR YOUR OTHER

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EOP Message Codes

Code	Message
	CARRIER HAS PAID THIS CLAIM IN FULL.
W60	THIS CLAIM WAS COORDINATED WITH YOUR OTHER CARRIER. A MERP CLAIM WON'T BE PROCESSED SINCE MAXIMUM MERP BENEFITS HAVE PREVIOUSLY BEEN PAID.
W61	THESE SERVICES WILL BE PROCESSED UNDER YOUR MERP COVERAGE AFTER YOU SUBMIT THE EXPLANATION OF BENEFITS FROM YOUR OTHER CARRIER.
W62	CLAIM WAS PROCESSED UNDER YOUR MERP COVERAGE. THE OTHER COVERAGE FIELD REPRESENTS THE AMT PAID BY MILLIMAN USA AND OTHER CARRIER COVERAGES.
W63	A MERP PAYMENT IS NOT BEING MADE SINCE YOUR MILLIMAN USA COVERAGE AND/ OR YOUR OTHER CARRIER HAS PAID THIS CLAIM IN FULL.
W64	ORTHOTICS ARE NOT COVERED UNDER THIS PROGRAM UNLESS PROVEN MEDICALLY NECESSARY.
W65	SUN CLIPS/CLIPS ARE NOT CONSIDERED A MEDICAL NECESSITY AND ARE NOT COVERED UNDER THIS PROGRAM.
W66	WARRANTIES ARE CONSIDERED A PERSONAL CONVENIENCE ITEM AND ARE NOT COVERED UNDER THIS PROGRAM.
W67	THIS CLAIM HAS BEEN PROCESSED UNDER YOUR MERP COVERAGE.
W68	MAXIMUM BENEFITS HAVE BEEN PAID ON THIS CLAIM.
W69	YOUR MAXIMUM MERP BENEFITS HAVE PREVIOUSLY BEEN PAID.
W70	THE CONTACT FITTING FEE IS ONLY PAYABLE WITH THE PURCHASE OF CONTACTS.
W71	THE DIFFERENCE BETWEEN THE BILLED CHARGE AND THE BENEFIT AMOUNT IS A PROVIDER ADJUSTMENT AND IS NOT THE PATIENT'S RESPONSIBILITY.
W72	YOUR DRUG PROGRAM DOES NOT COVER ITEMS THAT MAY BE PURCHASED WITHOUT A PRESCRIPTION.
W73	WE ARE UNABLE TO PRE-DETERMINE THE DENTAL BENEFITS AVAILABLE FOR THE NEXT CALENDAR YEAR. PLEASE RE-SUBMIT IN JANUARY.
W74	INAPPROPRIATE BILLING. PROVIDER WRITE-OFF.
W75	WE'VE COORDINATED THIS CLAIM WITH YOUR PRIMARY INSURANCE PLAN.
W76	REPLACEMENT CROWN BUILDUP IS SUBJECT TO CROWN LIMITATIONS. PLEASE REFER TO YOUR BENEFIT BOOKLET.
W77	REPLACEMENT OF AN EXISTING CROWN, INLAY, ONLAY OR LABIAL VENEER IS LIMITED. PLEASE REFER TO YOUR BENEFIT BOOKLET.
W78	REPLACEMENT OF AN EXISTING PARTIAL, FIXED BRIDGEWORK, OR COMPLETE DENTURE IS LIMITED. PLEASE REFER TO YOUR BENEFIT BOOKLET.

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EOP Message Codes

Code	Message
W79	COOPER CLINIC PAYMENT AGREEMENT. MEMBER NOT LIABLE FOR CHARGES EXCEED- ING THE BLUE CROSS ALLOWED AMOUNT. AGREEMENT EXPIRES 12-31-05.
W80	THE CHARGE EXCEEDS THE ALLOWABLE AMOUNT FOR THIS SERVICE.
W81	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT HAS APPLIED AN ALTERNATIVE ALLOWANCE OF A LESS COMPLICATED EXTRACTION.
W82	BASED ON THE INFORMATION SUBMITTED, OUR DENTAL CONSULTANT APPLIED AN ALTERNATIVE ALLOWANCE.
W84	OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THAT THIS SERVICE ISN'T MEDICALLY NECESSARY
W85	MISROUTED CLAIMS FOR THESE SERVICES NEED TO BE SUBMITTED TO: MHN PO BOX 14621, LEXINGTON, KY 40512-4621
W86	BY REPORT-PRICED PER MANUFACTURER'S INVOICE
W87	BY REPORT-PRICED PER MANUFACTURER'S SUGGESTED RETAIL PRICE.
W88	BY REPORT-NO INVOICE/MSRP-PRICED AT % OF BILLED CHARGES
W89	CLAIM IS NOT DENIED - IT IS PENDING PENSION BOARD APPROVAL
W90	THIS CLAIM HAS BEEN DENIED BY THE PENSION BOARD.
W91	THE PENSION BOARD IS WAITING ON RECEIPT OF OTHER HEALTH INSURANCE INFORMATION FROM THE MEMBER.
W92	THE PENSION BOARD HAS APPROVED THIS CLAIM FOR PROCESSING.
W93	BENEFITS ARE NOT PROVIDED FOR THIS SERVICE SINCE YOU SIGNED AND ACCEPTED A RIDER FOR THIS CONDITION AT ENROLLMENT.
W94	PROCESSED THROUGH THE BLUECARD PROGRAM
W95	PROVIDER: CLAIM APPEARS TO BE A DUPLICATE. IF CORRECTED CLAIM, INDICATE CORRECTION OR USE CORRECTED CLAIM COVER LETTER AND RETURN.
W96	MEDICAL EXPENSE REIMBURSEMENT PLAN PAYMENT HAS BEEN EXHAUSTED.
WA1	WE'VE COORDINATED THIS CLAIM WITH YOUR PRIMARY INSURANCE PLAN.
XU1	UM UNLIMITED UNITS (EXCD_STS=S)
Z01	INFO ONLY: THE CLAIM NOTED ABOVE HAS BEEN FINALIZED WITH YOUR PROVIDER HOWEVER, OUR RECORDS INDICATE THAT THIS EOB WAS NOT MAILED.
Z02	INFO ONLY: THE CLAIM NOTED ABOVE HAS BEEN FINALIZED WITH YOUR PROVIDER HOWEVER, OUR

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EOP Message Codes

Code	Message
	RECORDS INDICATE THAT THIS EOB WAS NOT MAILED.
Z05	WE ARE UNABLE TO REVIEW FOR ADDITIONAL ALLOWANCE FOR MODIFIER 22 WITHOUT SUPPORTING DOCUMENTATION. PLEASE SUPPLY THE INFORMATION.
Z17	ALLOWANCE BASED ON INGENIX
Z19	DENTAL ACCIDENT LIMIT HAS BEEN MET.
Z46	THIS SERVICE IS NOT COVERED UNDER YOUR MEDICAL PLAN, IT MAY BE COVERED UNDER YOUR PHARMACY PLAN
Z54	APPLICATION OF LOCAL DELIVERY OF CHEMOTHERAPEUTIC AGENTS IS ALLOWABLE ONCE PER TOOTH AND AT LEAST FOUR WEEKS AFTER CONVENTIONAL THERAPY.
Z56	THE PATIENT IS RESPONSIBLE BECAUSE MEDICARE DOES NOT COVER THIS SERVICE.
Z57	THIS CLAIM HAS BEEN SENT TO THE LOCAL BCBS FOR PROCESSING
Z63	THE CHARGE FOR THIS SERVICE ISN'T AN ALLOWED CHARGE.
Z67	BENEFITS ARE NOT PROVIDED FOR THIS SERVICE SINCE YOU SIGNED AND ACCEPTED A RIDER FOR THIS CONDITION AT ENROLLMENT.
Z68	THIS CLAIM HAS BEEN COORDINATED TO MEDICARE'S ALLOWABLE.
Z70	MAXIMUM BENEFITS HAVE BEEN PROVIDED FOR THIS CONTRACT PERIOD.
Z72	THE AK TEMP CARE PLAN DOES NOT COVER PRE-EXISTING CONDITIONS
Z73	THE LIFETIME BENEFIT FOR THIS TYPE OF SERVICE HAS BEEN USED, NO FURTHER COVERAGE IS AVAILABLE FOR THIS SERVICE.
Z74	THE LIFETIME BENEFIT FOR THIS TYPE OF SERVICE HAS BEEN USED, SO NO FURTHER COVERAGE IS AVAILABLE FOR THIS SERVICE.
Z75	DUE TO HURRICANE KATRINA, SERVICES ARE BEING PAID AT THE IN-NETWORK BENEFIT LEVEL UNTIL 10/31/2005.
Z76	DUE TO HURRICANE KATRINA, SERVICES ARE BEING PAID AT THE IN-NETWORK BENEFIT LEVEL UNTIL 10/31/2005.
Z77	THE LIFETIME BENEFIT FOR THIS TYPE OF SERVICE HAS BEEN USED, NO FURTHER COVERAGE IS AVAILABLE FOR THIS SERVICE.
Z78	THE PLAN DOESN'T COVER THIS SERVICE.
Z79	THIS CLAIM PRICED ACCORDING TO THE PROVIDER'S APC CONTRACT.
Z81	WE ARE APPLYING DOLLARS BACK TO YOUR CLAIMS HISTORY FROM A SETTLEMENT. NO ACTION IS

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EOP Message Codes

Code	Message
	REQUIRED.
Z84	CHARGES HAVE BEEN APPLIED TO YOUR MEDICARE PART A DEDUCTIBLE.
Z85	THE DIFFERENCE BETWEEN BILLED CHARGES AND MEDICARE'S ALLOWED AMOUNT IS THE RESPONSIBILITY OF THE PROVIDER.
Z86	THE DIFFERENCE BETWEEN BILLED CHARGES AND MEDICARE'S ALLOWED AMOUNT IS YOUR RESPONSIBILITY SINCE THE PROVIDER DID NOT ACCEPT ASSIGNMENT.
Z87	CHARGES HAVE BEEN APPLIED TO YOUR MEDICARE PART B DEDUCTIBLE.
Z88	THE CHARGE FOR THIS SERVICE IS INCLUDED IN THE TRANSPLANT GLOBAL PATIENT CARE.
Z89	ASSISTANT SURGEON NOT ALLOWED FOR THIS PROCEDURE
Z90	A COMPLETE MEDICARE EXPLANATION OF BENEFITS IS REQUIRED AND WAS NOT RECEIVED WITH THE CLAIM SUBMITTED.
Z91	BENEFITS FOR SERVICES ARE DENIED BASED ON INFORMATION SUPPLIED TO US. CHARGES ARE RELATED TO AN INCIDENT ANOTHER PARTY IS RESPONSIBLE FOR.
Z92	WE CAN'T PROCESS THIS CLAIM UNTIL THE INCIDENT QUESTIONNAIRE WE SENT THE MEMBER IS FULLY COMPLETED, SIGNED AND RETURNED
Z93	BENEFITS FOR SERVICES ARE DENIED BASED ON INFORMATION SUPPLIED TO US. CHARGES ARE RELATED TO AN INCIDENT ANOTHER PARTY IS RESPONSIBLE FOR.
Z94	WE CAN'T PROCESS THIS CLAIM UNTIL THE INCIDENT QUESTIONNAIRE WE SENT THE MEMBER IS FULLY COMPLETED, SIGNED AND RETURNED
Z95	THIS PLAN DOES NOT COVER SEALANTS ON PRIMARY TEETH.
Z98	WE HAVE RECEIVED YOUR CLAIM AND REQUESTED ADDT'L INFORMATION FROM THE MEMBER. ONCE THIS INFORMATION IS RECEIVED WE WILL CONTINUE OUR REVIEW.
Z99	ALL OR A PORTION OF THE AMOUNT WAS APPLIED TO YOUR CONTRACT BENEFIT DEDUCTIBLE.