

Edit Listing for Providers

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| 002 | Billing Provider Number Missing |
| 003 | Recipient Number Invalid |
| 004 | Claim Type Cannot Be Determined |
| 005 | Type of Admission is Default to 9 |
| 006 | Service From Date Invalid |
| 007 | Service Thru Date Invalid |
| 008 | Service Thru Date Less Than Service From Date |
| 009 | Billing Date Invalid |
| 010 | Service Date Greater Than Date of Receipt |
| 011 | Source of Admission is Default to 9 (EOB Only) |
| 012 | Total TPL Amount Not Numeric |
| 013 | Provider Cannot Submit This Invoice Type |
| 014 | Employment Indicator Invalid (Turned Off) |
| 015 | Accident Indicator Invalid (EOB Only) |
| 016 | Recipient Number is Missing |
| 017 | Multiple Levels of Care Billed on the Same Document |
| 018 | Missing/Invalid Primary Diagnosis |
| 019 | More Than Two Pages of UB82 Document Billed |
| 020 | Well Child Exams Must be Billed on EPSDT Screening Forms |
| 021 | Invalid Units of Service – Defaulted to 001 or Zeros (EOB Only) |
| 022 | Line Billed Charges Missing or Invalid |
| 023 | Patient Name is Missing |
| 024 | Invalid Units of Service |
| 025 | Units of Service are Not Equal to Days Billed |
| 026 | Invalid Date of Onset |
| 027 | HCPCS Code Billed is Not One of the Lab or Surgical Procedures (EOB) |
| 028 | Procedure/Drug Missing or Invalid |
| 029 | Attending Physician Missing |
| 030 | Non-Covered Revenue Charge is Greater Than Revenue Charge |
| 031 | This Line is Printed For Information Only (EOB Only) |
| 032 | HCPCS Code Cannot Be Billed (EOB Only) |
| 033 | Only Lab Charges Can Be Billed With HCPCS (EOB Only) |
| 034 | Override Code Invalid |
| 035 | Cover Day Set to Accommodation Days |
| 036 | Revenue Lab Charges Not Allowed - Rebill HCPCS Lab Codes |
| 037 | HCPCS are Required For Surgical or Lab Procedures |
| 038 | Invalid Adjustment Reason |
| 039 | Former CCN Invalid |
| 040 | Sum of Non-Covered Charges Not Equal Total Non-Covered |
| 041 | Accommodation Revenue Codes Not Allowed |
| 042 | Invalid/Missing Revenue Charge |
| 043 | Admission Date Invalid or Conflicts With From Date of Service |
| 044 | Patient Status Invalid |
| 045 | Surgery Procedure Date Invalid or Not Within Dates of Service |
| 046 | Covered Days Plus Non-Covered Days Not Equal to Dates of Service |
| 047 | Covered Days Not Numeric |

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|-----|--|
| 048 | Revenue Code is Missing or Not Numeric |
| 049 | Source of Admission Invalid For Newborn |
| 050 | Occurrence Code Invalid |
| 051 | Sum of Accommodation Days Not = Total Days |
| 052 | Hour of Admission Invalid |
| 053 | Patient Status is Discharged/Died/Discontinued and Date of Discharge is Statement Thru Date (EOB Only) |
| 054 | Oxygen Billed Requires Oxygen Invoice |
| 055 | Attachment Sent With Oxygen Billed Requires Review |
| 056 | Type of Bill Code Invalid or Not Valid for Alaska Medicaid |
| 057 | Type of Admission is Default to 2 (EOB Only) |
| 058 | Patient Status Conflicts With Type of Bill |
| 059 | Non-Covered Days are Invalid |
| 060 | Co-Payment Amount is Invalid |
| 061 | Former CCN is Missing |
| 062 | Invalid/Missing Blood Furnished |
| 063 | Pints of Blood Replaced Invalid |
| 064 | Pints of Blood Not Replaced Invalid |
| 066 | Special Program Code Invalid (EOB Only) |
| 067 | Missing/Invalid Accommodation Days/Units of Service |
| 068 | Total Charges Missing or Not Equal to Sum of Covered Charges Plus Non-Covered Charges (EOB Only) |
| 069 | Non-Covered Charges are Invalid |
| 070 | Private Room Charges Require Justification |
| 071 | Occurrence Date is Invalid |
| 072 | No Accommodation Revenue Codes Entered |
| 073 | Attachment Sent With Private Room Charges Requires Review |
| 074 | Surgery Procedure Missing/Invalid |
| 075 | No Surgical Procedure Identified With Operating Room Charge |
| 076 | Resubmittal Turnaround Document Filing Limit Exceeded |
| 077 | Service Dates Span More Than One Day Service |
| 078 | Non-Covered Equals or Exceeds Billed Charges |
| 079 | Claim Revenue Codes and Charges Have Been Combined (EOB Only) |
| 080 | Provider Signature Missing |
| 081 | Procedure Code Billed is Not Allowed |
| 082 | Invalid Lab Procedure - Rebill With Proper Code |
| 083 | At Least One Screening Code Must Be Billed |
| 084 | Medicare Paid is Greater Than Medicare Billed |
| 085 | Sum of Deductibles Must Equal Medicaid Billed |
| 086 | Recipient Number on All Lines of the Document is Not The Same |
| 087 | Provider Number on All Lines of the Document is Not The Same |
| 090 | SX Connectivity/Transaction Error |
| 091 | Missing or Invalid Data |
| 092 | Missing/Invalid Date Written |
| 093 | Missing or Invalid Information for COB |
| 094 | Bill Medicare Part D |

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|-----|---|
| 099 | Pend for Review |
| 100 | Submit More Justification For Modifier or Delete Modifier |
| 101 | Two Surgeons or Unusual Services Pend For Review |
| 102 | Multiple Modifiers Pend For Review |
| 103 | Invalid or Missing Place of Service |
| 104 | Procedure Code Modifier Invalid |
| 105 | Place of Service Invalid for Provider Type and Specialty |
| 106 | Round Trip is Not Allowed for Taxi's Services |
| 108 | Origin/Destination Missing |
| 109 | Requesting Person's Signature Missing |
| 110 | Authorizing Person Missing |
| 121 | Prescriber Missing |
| 122 | Prescriber Invalid |
| 123 | Days Supply Invalid |
| 124 | Date of Service After Current Date |
| 125 | Prescription Number Invalid or Missing |
| 126 | CAMA 3 Rx Limit Exceeded |
| 128 | Refill Code Invalid |
| 129 | Out of Sequence Reversal on Partial Fill Transaction |
| 130 | Associated Partial Fill Transaction Not on File |
| 131 | Completion Trans not Permitted with Same DOS as Partial |
| 150 | Time Sheet Attachment Required |
| 151 | Attachment Sent With Personal Care Service Requires Review |
| 175 | Individual Provider Cannot Bill for Another Individual |
| 176 | Invalid Charge Billed to Medicare |
| 177 | No Deductible or Coinsurance Crossed Over From Medicare |
| 178 | Invalid Medicare Payment |
| 179 | Invalid Cash Deductible Amount |
| 180 | Invalid Blood Deductible Amount |
| 181 | Invalid Coinsurance Amount |
| 182 | X-Over Amount Billed Greater Than Amount Billed to Medicare |
| 184 | Medicare Payment Date Must Be Greater Than DOS and Less Than CCN Date |
| 185 | Medicare Payment Date Invalid/Missing |
| 186 | Institutional Type Invalid or Missing |
| 187 | Paper Crossover Claim Requires Medicare EOMB Attachment |
| 188 | Attachment Sent With Paper Crossover Requires Review |
| 189 | Servicing Provider NPI not Submitted on Claim |
| 190 | Billing Provider NPI not Submitted on Claim |
| 191 | Billing NPI not Matched – no Matching Medicaid Identifier |
| 192 | Billing Provider NPI not Matched – Multiple Medicaid Identifiers |
| 193 | Servicing Provider NPI not Matched – no Matching Medicaid Identifier |
| 194 | Prov No Does Not Match Lockin Prov No |
| 195 | Claim Must Have FCHP Provider or Affiliate |
| 196 | IHS Provider Not Eligible For CAMA Payment For IHS Beneficiary |
| 198 | Provider Cannot Bill Claim Type |
| 199 | Servicing Provider Inactive or Not Eligible on Dates of Service |

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| 200 | Provider Not on File |
| 201 | Exceptional Prior Authorization Review |
| 202 | Adjustment/Void Claim Exceeds 30 Days Filing Time Limit |
| 203 | Adjustment/Void/Rebill Claim Exceeds 6 Months Filing Time Limit |
| 204 | Provider Inactive or Not Eligible on Dates of Service |
| 205 | Provider Not Enrolled For EMC, POS or EDI Billing |
| 206 | Date of Service Spans Provider Fiscal Year |
| 207 | Provider on Prepayment Review |
| 208 | Out-of-State Provider Requires Manual Pricing |
| 209 | Provider Cannot Bill as Individual |
| 210 | Invalid Provider Number - Deny to 9's |
| 211 | Rendering Provider Number Missing |
| 212 | Servicing Provider Not on File |
| 213 | Servicing Provider is Not a Member of Billing Provider Group |
| 214 | Rendering Only Provider Cannot Bill |
| 215 | Recipient Not on File - Sticker or Attachment Present |
| 216 | Recipient Not on File - No Sticker/Attachment |
| 217 | Recipient Not Eligible on Dates of Service - Sticker/Attachment Present |
| 218 | Recipient Not Eligible on DOS - No Sticker/Attachment |
| 219 | Recipient Not Eligible For Services Rendered |
| 220 | State Pend - Recipient Not on File |
| 221 | Recipient Name Mismatch - Sticker/Attachment Present |
| 222 | Recipient Name Mismatch - No Sticker/Attachment (Recycle) |
| 223 | Recipient Name Mismatch - No Sticker/Attachment |
| 224 | Date of Service is Prior to Date of Birth |
| 225 | Recipient Date of Death is Prior to Date of Service |
| 226 | Recipient On Medical Review |
| 227 | Recipient Requires Prior Authorization |
| 228 | Provider Not Valid for Primary Care Recipient |
| 229 | Co-Payment For Medicaid Funded Services is Not Allowed |
| 230 | Provider Not Allowed to Bill Professional Component |
| 231 | Procedure/Formulary Provider Type Restrictions |
| 232 | Procedure/Drug Code is Not on File or Not Valid For Provider or Modifier |
| 233 | Procedure/Formulary Not Covered on DOS |
| 234 | Procedure/Formulary Age Restriction |
| 235 | Procedure/Formulary Sex Restriction |
| 236 | Procedure/Formulary Place of Service Restriction |
| 237 | Procedure/Formulary Provider Specialty Restriction |
| 238 | Procedure/Formulary Max Units Exceeded |
| 239 | Service Requires Prior Authorization |
| 240 | Procedure/Formulary Diagnosis Restriction |
| 241 | Provider Master File Does Not Have Valid Price For DOS |
| 242 | Procedure/Formulary File Does Not Have Valid Price for DOS |
| 243 | Must Bill Valid ICD9 Surgical Procedure Code in UB82 Block 84 - 85 |
| 244 | N0 P/F Pricing Action Code For DOS |
| 245 | CAMA Recipients are Only Eligible For Medical Supplies |

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| 246 | Brand Drugs Not Covered Unless Required by Prescriber |
| 247 | Control File No Price |
| 248 | Unlisted Procedure Requires Written Justification - Pend For Review |
| 249 | Zero Payment on Paid Claim |
| 250 | Global Obstetric Care is Not Allowed Without TPL |
| 251 | Billed Exceeds Allowed |
| 252 | Diagnosis Not on File |
| 253 | Diagnosis Date Restriction |
| 254 | Diagnosis Age Restriction |
| 255 | Diagnosis Sex Restriction |
| 256 | Diagnosis File Procedure Restriction |
| 257 | Recipient Not on File - No Sticker/Attachment |
| 258 | Recipient Not Eligible on Dates of Service - No Sticker/Attachment |
| 259 | Cross-Over Claim Exceeds Filing Time Limit - Submit Proof of Timely Filing |
| 260 | State Pend - Recipient Name Mismatch |
| 261 | Provider Not Authorized For Billed Services |
| 262 | Provider Not Certified For the Lab Codes |
| 263 | Recipient Not on File - Requires Valid Sticker or Attachment |
| 264 | Recipient is Medicare Part A Eligible |
| 265 | Recipient is Medicare Part B Eligible |
| 266 | Recycle For LTC Recipient Showing Admission |
| 267 | Annual Physical Examine is Covered in LTC All-Inclusive Rate |
| 268 | Claim Exceeds Filing Time Limit - Submit Proof of Timely Filing |
| 269 | Provider Type Not Valid For EPSDT Services |
| 270 | Claim Spans State Fiscal Year |
| 271 | Referring Provider Required |
| 272 | Medicare Part A EOMB Sent With Claim Requires Review |
| 273 | Medicare Part B EOMB Sent With Claims; Requires Review |
| 274 | Total Document Charges Not Equal Sum of Charges - Replaced By System (EOB) |
| 275 | Timely Filing Attachment Requires Review |
| 276 | High Variance Error - Fixed Variance |
| 277 | Low Variance Error - Fixed Variance |
| 278 | Claim Exceeds 12 Month Filing Time Limit |
| 279 | Invalid Lab Procedure Code |
| 280 | Service Not Covered By Medicaid |
| 281 | Pend For Manual Pricing |
| 282 | High Variance Error - Procedure Specific |
| 283 | Low Variance Error - Procedure Specific |
| 284 | Manual Price Exceeds Billed Charges |
| 285 | Unlisted Procedure Requires Written Explanation |
| 286 | Abortion - Pend For Review |
| 287 | Sterilization - Pend For Review |
| 288 | Procedure/Item Not Covered For Medicaid |
| 289 | Medical Justification/Medical Records Required |
| 290 | State Pend - Recipient Not Eligible on Dates of Service |
| 291 | Pend For Review |

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| 292 | Hysterectomy - Pend For Review |
| 293 | Anesthesiologist Must Bill the ASA Codes |
| 294 | Surgeon Must Bill Surgery Code Modified by 47 |
| 295 | ASA Codes Must Not be Modified by 47 |
| 296 | Recipient Not Eligible on Dates of Services - Requires Valid Sticker/Attachment |
| 297 | Diagnosis on Review |
| 298 | Diagnosis Not Covered |
| 299 | Duplicate Surgeries on the Same Document |
| 300 | Ambulatory Surgical Procedure Requires Justification |
| 301 | Weekend Admission Not Allowed (EOB) |
| 302 | Invalid Revenue Code Billed For Home Health |
| 303 | Revenue Code Not Covered |
| 304 | Covered Days Reduced to PAS/LOS Maximum (EOB) |
| 305 | Covered Days Reduced to PRO/W Allowance |
| 306 | Billed Co-Payment is Less Than State Required Amount (EOB) |
| 307 | Psychiatric Hospital Admission Requires PRO/W Certification |
| 308 | Hospital Admission Requires PRO/W Certification For Diagnosis |
| 309 | Justification of Ambulatory Surgical Procedure Attachment Requires Review |
| 310 | Inpatient Psychiatric Age Restriction |
| 311 | Hospital Admission Requires PRO/W Certification For Procedure |
| 312 | Invalid Modifier 47, Rebill With ASA Code |
| 313 | Duplicate of Bilateral Surgery (Modifier 50) |
| 314 | Service Requires Prior Authorization - Pend For Review |
| 315 | Procedure Modifier Billed Requires Medical Justification |
| 316 | Modifier Not Valid For This Procedure |
| 317 | Procedure Modifier Restriction |
| 318 | PRO/W Authorization is Required For GRM Recipient |
| 320 | Unlisted Procedure Manually Price |
| 321 | Recipient First Name Does Not Match First Name on File |
| 322 | No Valid Revenue or HCPC Code Billed |
| 323 | Procedure Not Covered For Assistant Surgeon |
| 324 | TPL Attachment Review |
| 325 | Financial CCN Number Missing |
| 326 | Total of Deductible and Coinsurance is Greater Than Amount Billed |
| 327 | Procedure Not Allowed For Mental Health Provider |
| 328 | LTC Approval Date Must Not Be More Than 30 Days Prior To Admit Date |
| 329 | PA Required For GRM Inpatient Dental Services |
| 330 | Facility Not Qualified For Level of Care Billed |
| 331 | No Pre-Admission Screening Available For Claims Service Dates |
| 332 | Claim Spans LTC Thru Date |
| 333 | LOC Not Authorized by Pre-Admission Screening |
| 334 | No Patient Liability in Effect For Service Dates |
| 335 | Patient Liability Exceeds or Equals Allowed Amount |
| 336 | Provider is Not Authorized For the Patient |
| 337 | LTC Claims Must Bill at Least on Rev Code in the 191 - 195 Range |
| 338 | Place of Service # Limited to Mental Health Services |

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| 339 | Recipient Changes Patient Status After He is Discharged or Transferred |
| 340 | Provider File Does Not Have an AWP Percentage or Dispensing Fee For Determining the Price |
| 341 | Invalid Procedure Code For Dieticians |
| 342 | Payment is Restricted to Recipients Under the Age of 22 |
| 343 | Payment Amount Exceeds Established Limit |
| 344 | Hospice Provider Billing on a Home Health Claim Can Only Bill Certain Codes |
| 345 | Podiatrist May Only Bill Certain Codes |
| 346 | Claim Patient Liability (PL) Exceeds Recipient File's PL |
| 347 | Recipient File's Patient Liability Exceeds Provider PL- Cutback (EOB) |
| 348 | Medicare Was Billed Incorrect HIC. Rebill Medicare |
| 349 | Ancillary Code Billed Requires Prior Authorization |
| 350 | Psychiatric Revenue Code Requires Prior Authorization |
| 351 | Deny to 9999998 Provider - Process Error |
| 352 | No ASC Price on File For the Date of Service |
| 353 | Private Duty Nurses Cannot Bill with Hospice Codes |
| 354 | All Rental Requires Prior Authorization |
| 355 | Attachment Indicator Review Check |
| 356 | TPL Indicated on Claim, No TPL Attachment |
| 357 | TPL Indicated on Claim, No TPL Indicated on Master File |
| 358 | Bill Third Party Resource |
| 359 | More Than One Policy Covers Services Rendered |
| 360 | Sonogram Services Require Valid Diagnosis Code |
| 361 | Respiratory Therapist Needed to Perform These Services |
| 362 | Dental Care For Adults is Limited to Emergency Treatment Only |
| 363 | Chiropractic Services For Children Under 6 Require Prior Authorization |
| 364 | Non Rebate Manufacturer |
| 365 | Procedure Requires Primary Tooth Code(s) |
| 366 | Procedure Requires Permanent Tooth Code(s) |
| 367 | Procedure Requires One or More Valid Tooth Surface Code(s) |
| 368 | Procedure Requires Valid Tooth Code |
| 369 | Procedure Does Not Require Surface Code(s) (EOB) |
| 370 | Procedure Does Not Require Tooth Code (EOB) |
| 371 | Subsequent Visit is Limited to One Per Month (EOB) |
| 372 | Only One Unit Per Day May Be Billed (EOB) |
| 373 | Sum of Days/Hours Exceed Dates of Service |
| 374 | Invalid Code For Case Management |
| 375 | Counseling and Day Treatment May Bill Only Four Hours Per Day |
| 376 | Recipient Over 21 Requires PA For These Dental Codes |
| 377 | Group Therapy is Limited to Five Units Per Day (EOB) |
| 378 | Resin Restoration Not Covered For Posterior Teeth |
| 379 | OBRA Service Not Covered |
| 380 | Surgical Procedure Not Covered |
| 381 | All Compound Drugs Require Manual Review |
| 382 | LTC Claim DOS Spans Into Another Calendar Month |
| 383 | Only Two Units Per Day May Be Billed (EOB) |
| 384 | Place of Service Limited to Mental Health Clinics |

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| 385 | Home Health Services Not Covered For LTC Recipient |
| 386 | Prevailing Fee Not On File |
| 387 | Procedure Code Not Valid For Provider |
| 388 | Diagnosis Code Not Valid For CAMA Client |
| 389 | Invalid Prescriber for Primary Care Recipient |
| 390 | Unit Dose Dispensing Fee Applied (EOB) |
| 391 | Unit Dosage Only Permitted For NH Recipients (EOB) |
| 392 | Review of ASC Invoice Required |
| 393 | Zero Length of Stay for Diagnosis |
| 394 | Days Supply Exceeds 30 Days Maximum |
| 395 | GRM Recipient Not Eligible For Services by Psychiatric Provider |
| 396 | GRM Recipient Not Eligible For Psychiatric Procedure Code |
| 397 | TPL Pediatric Services - Pay and Bill (EOB Only) |
| 398 | TPL Pregnancy Related - Pay and Bill (EOB Only) |
| 399 | TPL Court Order - Pay and Bill (EOB Only) |
| 400 | TPL Court Order - 30 Days Have Passed Since Date of Service (EOB Only) |
| 402 | TPL Override - Pay and Bill (EOB Only) |
| 403 | Servicing Provider NPI not Matched – Multiple Medicaid Identifiers |
| 404 | TPL Avoidance Match – TPL Resource (EOB Only) |
| 405 | TPL Avoidance Match – Medicare Resource (EOB Only) |
| 406 | Procedure Not Allowed For Vision Provider |
| 408 | Healthy Visit Not Covered Unless FCHP Member |
| 409 | Only Exam or Immunization Allowed for Healthy Visit |
| 413 | New E/M Service Not Allowed For Established Patient |
| 414 | Provider is Required To Have a CLIA Number |
| 415 | No CLIA Number on File For Provider |
| 416 | No CLIA Dates of Service Match For Provider |
| 417 | Not a Waivered CLIA Procedure Code |
| 418 | Provider Not Certified For CLIA Specialty Code |
| 419 | Handling Fee Only Allowed For Lab Work Performed Outside Office |
| 420 | Drug Charge Exceeds the Percentage of the Blue Book Price |
| 421 | Provider Restricted For This Lab Code |
| 422 | CLIA Lab Procedure Code is Not Valid For PPMP |
| 423 | Established E/M Replaces New E/M Service (EOB) |
| 425 | Procedure is Inappropriate For Patient's Sex (DENY) |
| 426 | Cosmetic Procedure Not Covered (DENY) |
| 427 | Unlisted Procedure Not Covered (DENY) |
| 428 | Possible Claim Check Duplicate |
| 429 | Assistant Surgeon Flag (Sometimes Acceptable) (TEST) |
| 430 | Claim Check Age Conflict (DENY) |
| 431 | Claim Check Experimental Procedure Code (DENY) |
| 432 | Claim Check Obsolete Procedure Code (DENY) |
| 433 | Procedure Rebundled Into New Procedure (DENY) |
| 434 | Procedure is Incidental to Primary Procedure (DENY) |
| 435 | Medical Visit Procedure Billed With Primary Procedure (DENY) |
| 436 | Procedure Rendered More Than One Time on Same Date (DENY) |

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| 437 | Procedure is Mutually Exclusive to Another Procedure (DENY) |
| 438 | Claim Check Age Conflict (DENY) |
| 439 | Claim Check Sex Conflict (DENY) |
| 440 | Procedure Does Not Require Assistant Surgeon (DENY) |
| 441 | Procedure Within Pre-Operative Time Period (DENY) |
| 442 | Procedure Within Post-Operative Time Period (DENY) |
| 443 | Procedure Added Due to Rebundling (EOB) |
| 444 | Procedure Added Due to Age Conflict (EOB) |
| 445 | Procedure Added Due to Sex Conflict (EOB) |
| 446 | Approved to Bypass Claim Check (EOB) |
| 447 | Claim Lines Sent to ClaimCheck Exceed Limit |
| 449 | Multiple Surgery Repricing |
| 450 | Intensity of Service Higher than Expected for Diagnosis |
| 451 | Procedure Not Expected for Diagnosis |
| 452 | Quantity Exceeds Program Maximum |
| 453 | Procedure Rebundled Into Another Procedure (VOID) |
| 454 | Incidental Procedure (Void) |
| 455 | Medical Visit (Void) |
| 456 | Service Rendered More Than Once on Same Date of Service (Void) |
| 457 | Mutually Exclusive (Void) |
| 458 | Multiple Surgery Line Added |
| 459 | Multiple Surgery Procedure (Void) |
| 461 | Pre-Operative Visit (Void) |
| 462 | Post-Operative Visit (Void) |
| 463 | New E/M Service (Void) (EOB) |
| 464 | Line Added for Multi-Unit Procedure Code (EOB) |
| 465 | Medicaid Allowable Amount Reduced By Other Insurance (EOB) |
| 466 | Multiple Components Billed |
| 468 | Duplicate global, technical (-TC) or professional (-26) billed |
| 469 | Invalid Procedure Code/Modifier Combination Voided (EOB) |
| 471 | Invalid Procedure Code / Modifier Combination |
| 474 | Procedure Code with Multiple Units for Same DOS (Deny) |
| 475 | Adjustments Not Allowed on Lines with EOB 464 (Deny) |
| 477 | Billing Provider NPI not Matched – Multiple Medicaid Identifiers - Review |
| 479 | Services must be billed with core service |
| 480 | Procedure Not Valid For Direct Entry Midwife |
| 481 | Provider Type/Specialty Not Authorized to Bill Modifier |
| 483 | Submit Appeal With Justification For Unpaid Units (EOB Only) |
| 484 | Claim Units Have Been Cut Back to Authorized Units (EOB Only) |
| 485 | Itemization of Charges Required For Out-of-State Transportation |
| 486 | Claim Data Does Not Match PA Data |
| 487 | Units Billed Have Been Exhausted |
| 488 | Invalid Claim Filed For QMB Med Subtype; Must be Crossover Claim |
| 489 | Eligibility Code 25 Pend for Review |
| 492 | NDC Missing or Invalid |
| 494 | Multiple Unit Procedure Code Voided (EOB) |

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|-----|---|
| 500 | Document Pend |
| 501 | Document Pend |
| 502 | Document Pend (RTD) |
| 503 | Screening Must Be on File for OBRA Recipients |
| 504 | Itemization Required for this Procedure |
| 513 | Modifier Requires Review |
| 521 | Duplicate Adjustment Records Entered |
| 522 | No History Record on File For This Claim |
| 523 | Original/Adjustment Provider Different |
| 524 | History Record Already Adjusted |
| 525 | Adjustment or Void Invalid For Previously Denied Claim |
| 526 | Credit Record is Missing |
| 527 | Claim Not Found On Online History |
| 528 | Cannot Adjust/Void the Same Cycle Batch Claim |
| 530 | State Pend - Claim Adjustment |
| 531 | Early Refill |
| 532 | Late Refill |
| 533 | DUR Excess Quantity |
| 534 | DUR Age Conflict |
| 535 | High Dose |
| 536 | High Dose Over Age |
| 537 | High Dose Under Age |
| 538 | Low Dose |
| 539 | Low Dose Over Age |
| 540 | Low Dose Under Age |
| 541 | Drug to Diagnosis Conflict |
| 542 | Drug to Drug Conflict |
| 543 | Pregnancy Conflict |
| 544 | Therapeutic Duplication |
| 545 | Pend For Review |
| 546 | Maximum Units per 30 Days Exceeded |
| 547 | PA Required MD/ANP Call 800-331-4475 |
| 548 | Non-preferred Drug, Approved |
| 549 | Non-preferred Drug, PA Required by Pharmacy |
| 550 | PA Number Not on PA File |
| 551 | Claim Provider Does Not Match PA Provider |
| 552 | Claim Recipient Does Not Match PA Recipient |
| 553 | Claim Procedure or Diagnosis Code Does Not Match PA |
| 554 | Claim Procedure Modifier Does Not Match PA |
| 555 | Invoice Type Does Not Match PA |
| 556 | From Service Date Outside Effective Date on PA |
| 557 | Thru Service Date Outside Effective Date on PA |
| 558 | PA Units or Dollars Have Already Been Exhausted |
| 559 | Prior Authorized Days Have Been Exceeded |
| 560 | Only 2 Screenings Allowed Per Waiver Year |
| 561 | Second Screening Not Allowed For Waiver Eligible Recipients |

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|-----|---|
| 562 | Screenings, Assessment, and Plan of Care Require a Referral Number |
| 563 | Only 1 Assessment is Allowed Per Recipient |
| 564 | Only 1 Plan of Care is Allowed Per Recipient Per Calendar Year |
| 565 | Ongoing Care Coordination Can't Be Billed in 1st Month of Waiver Eligibility |
| 566 | Reassessment Not Allowed With Other Care Coordination |
| 567 | Reassessment Limited to 1 Per Client's First Waiver Year |
| 568 | Reassessment Limited to 2 after Client's 1st Waiver Year |
| 569 | Payment Cutback to Maximum Daily Allowed Respite Amount (EOB) |
| 570 | Waiver Service and LOA Have Same DOS |
| 571 | Leave of Absence Limited to 12 Days Per Waiver Year |
| 572 | Waiver Service and LOA Have Same DOS |
| 573 | Supported Employment and Day Habilitation Have Same Overlapping DOS |
| 574 | Education and Day Habilitation Have Same DOS |
| 575 | Service Not Allowed; Same/Overlapping DOS as Adult Day Care |
| 576 | Recipient Not < 23 Years Old at Start of Education Waiver |
| 577 | Limit of 2 Meals Per Day Exceeded |
| 578 | Recipient < 21 Years Old Can't Receive Private Duty Nursing |
| 579 | Diagnosis Not Present on Both PDN Claim and PA |
| 580 | Claim Date of Service Spans Waiver Year |
| 581 | Provider Not Authorized For Services Billed |
| 582 | Ongoing Care Limited to 1 Per Month |
| 583 | Respite Care Hourly and Daily Codes Billed on Same DOS |
| 584 | Prior Authorization Record is Pended With Errors |
| 585 | Prior Authorization Record is Set To Review |
| 586 | Prior Authorization Record Has Been Denied |
| 587 | Service Not Allowed on Same or Overlapping DOS as Residential Supported Living Arrangements (Assisted Living) |
| 588 | Service Not Allowed on Same or Overlapping DOS as Family Habilitation Home Services |
| 589 | Family Habilitation Home Service Not Allowed on Same or Overlapping DOS as Other Waiver Services |
| 590 | Service Not Allowed on Same or Overlapping DOS as In-Home Habilitation Services |
| 591 | Family Directed Respite Not Allowed |
| 600 | PA Number Missing or Not Greater Than 0 |
| 602 | Admission Not Within 30 Days Before or After Prior Authorized Dates |
| 603 | Other Coverage 5 or 6 Not Allowed |
| 604 | Other Payer Amount Paid Less Than One Dollar |
| 605 | Prior Authorized Units or Dollars Exceeded (EOB) |
| 608 | Justification of Medical Necessity Attachment Requires Review |
| 610 | Send the Appropriate Chart/ER Notes For This Primary Care Recipient |
| 613 | Sterilization Attachment Required |
| 614 | Hysterectomy Attachment Required |
| 615 | Provider License Not Valid on Date of Service |
| 616 | Provider License Not Valid on Date of Service |
| 617 | Different Drug Entity Between Partial and Completion |
| 618 | Mismatch Cardholder ID – Partial to Completion |
| 630 | Therapeutic Leave Days Cutback to Limit of 12 (EOB) |

Edit Listing for Providers

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| 631 | Claim Patient Liability (PL) Exceeds Recipient File's PL in Two Consecutive Months |
| 632 | Consultation Voided Due to Surgery/Treatment Within 30 Days |
| 640 | Fee Reduced By Amount Previously Paid For Associated Services (EOB) |
| 650 | Semi-Annual Assessment Limited to 2 Hours (8 -1/4 hrs) Per Calendar Year |
| 651 | Adult Client Support Yearly Service Limit Exceeded |
| 652 | Pharmacologic Management Yearly Service Limit Exceeded |
| 653 | Aggregate Limit of Individual, Group, and Family Therapy Yearly Service Limit Exceeded |
| 654 | Psychiatric Assessment Yearly Service Limit Exceeded |
| 655 | Psychological Testing Yearly Service Limit Exceeded |
| 656 | 16 Quarter Hour Units of Psychosocial Rehabilitation Services Allowed Per Day |
| 657 | Psychosocial Rehabilitation Services Limited to 960 Quarter Hour Units Per Calendar Year |
| 658 | Intake Assessment Yearly Service Limit Exceeded |
| 659 | Crisis Intervention Yearly Service Limit Exceeded |
| 660 | Psychosocial Assessment Yearly Limit Exceeded |
| 661 | Crisis Intervention Daily Service Limit Exceeded |
| 662 | Recipient Support Daily Service Limit Exceeded |
| 663 | Functional Assessment Yearly Service Limit Exceeded |
| 664 | Individual Skill Development – Children Yearly Service Limit Exceeded |
| 665 | Individual Skill Development – Adult Yearly Service Limit Exceeded |
| 666 | Group Skill Development Yearly Service Limit Exceeded |
| 667 | Family Skill Development Yearly Service Limit Exceeded |
| 668 | Case Management Yearly Service Limit Exceeded |
| 669 | Mental Health Service Limit Exceeded and Cutback Performed |
| 670 | Two Dental Exams Allowed Per Year |
| 673 | Services Not Allowed on Tooth Previously Extracted |
| 676 | Root Canal Limited to Once in a Lifetime Per Tooth |
| 680 | Adult Dental Annual Benefit Exceeded |
| 681 | Cutback to Annual Adult Dental Maximum Benefit Amount |
| 683 | Limited to One Per Tooth Per Recipient Per Provider |
| 689 | Two Prophylaxis Allowed Per Year |
| 690 | Fluoride Treatment Limited to Two Per Year |
| 691 | Emergency Services Cannot Include Routine Services |
| 693 | Continuous Dates of Service For Interim Billing Required |
| 694 | Payment Exceeds Billed |
| 695 | Surgical Tray Not Approved |
| 700 | Procedure Already Performed Once in Recipient's Lifetime |
| 701 | Consultation Cannot Be Billed By Provider Who Performs the Surgery |
| 702 | Limit the Number of Days of Service for ESRDs to 90 |
| 703 | Lifetime Procedure With Attachment |
| 704 | Personal Care Services Must Not Exceed 35 Hours per Week |
| 705 | Personal Care Monthly Limit Exceeded |
| 706 | Full and Half Day Treatment Codes May Not Be Billed on the Same Day |
| 707 | Exceeds 12 Service Dates Per Calendar Year |
| 708 | Exceeds Visit Limits For Calendar Year For Specific GRM Recipients |
| 709 | One Circumcision, Clamp Procedure: Newborn |
| 710 | Cannot Fill a Tooth Surface That Has Been Sealed |

Edit Listing for Providers

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|-----|---|
| 711 | Service Not Covered - OV Limitations Exceeded for Fiscal Year |
| 712 | One New Patient Visit Allowed Per Recipient Per Provider Per X Years |
| 713 | One Family APGAR Per Six Months |
| 714 | One Development of Plan of Care Per Six Months |
| 715 | Subsequent Visit Limited To 800 Dollars Per Month in a 10 Month Period |
| 716 | Monthly and Hourly Subsequent Visit Cannot Be Billed in the Same Month |
| 717 | Case Management Limited to 1 per Calendar Month |
| 718 | One Risk Assessment/Care Per Six Months |
| 719 | Routine Pre-Post Care Visits Should Be Part of Major Surgery |
| 720 | Care Monitoring is Limited to 70 Units Per Rolling 12 Months |
| 721 | One Physician Nursing Home (SNF/ICF or ICF Level) Visit Per 30 Days |
| 722 | Justification For Multiple Physician Visits Requires Review (edit not in use) |
| 723 | Two Consultation Per Recipient, Per Diagnosis, Per 90 Days |
| 724 | Rental or Purchase of Ventilator on History |
| 725 | One Patient Assessment For Ventilators Per Six Months, Attachment Present |
| 726 | One Patient Assessment For Ventilators Per Six Months, No Attachment |
| 727 | Exceeds 8 Days GRM Hospitalization Per Rolling Year |
| 728 | Full and Half Day Treatment Codes Cannot Be Billed on Overlapping Days |
| 729 | Not Allowed on Same DOS: AB/CD or 15 min/daily PCA Services |
| 730 | Dental Office Visit Cannot be Billed with Other Services on the Same Day |
| 731 | Limit One Replacement of Dentures Every 5 Years |
| 732 | Prosthodontics Fee Includes 6 Months of Adjustments |
| 733 | Perm Dentures Made Within One Year of Temporary Dentures |
| 734 | Oral Surgery All-Inclusive Fee (Including Anesthesia or Post Operative) Per 14 Days |
| 735 | Palliative/Sedative Treatment Exceeds 2 Times Per Tooth |
| 736 | Components of the Complete Tooth Restoration Procedure Cannot be Billed |
| 737 | PCA Services Exceeded 96 Quarter Hour Units on the Same DOS |
| 747 | Procedure Not Allowed For Reversal of Sterilization |
| 748 | D&C Not Allowed in Conjunction With Hysterectomy |
| 749 | Total Care vs Ante/Post & Delivery By Same Provider Not Allowed |
| 750 | Total Care vs Ante/Post/Delivery - Different Provider |
| 751 | Dietician May Only Bill Initial Visit Once Per 12 Months |
| 752 | Dietician Limited to 24 Subsequent Per Year (Attachment Not Present) |
| 753 | Dietician Limited to 24 Subsequent Per Year (Attachment Present) |
| 754 | Detoxification Exceeds Limit |
| 755 | Procedure Allowed Once in a 325-Day Period |
| 757 | Counseling and Day Treatment Cannot Exceed 150 Hours Per Year; PA Required |
| 758 | Detoxification Cannot Exceed 4 Days - PA Required |
| 759 | Detoxification Cannot Exceed One 24-Hour Service Per Day |
| 761 | Component Tests Not Allowed Same Day as CBC |
| 762 | Therapy Limit Exceeded Screening Required |
| 763 | Exceeds Multi-Channel Test Limit - Blood Analyzer Code Required |
| 764 | One Screening Per Year |
| 765 | Diagnosis Services Limited to 4 Per Rolling Year |
| 769 | Activity Therapy Limit Exceeded |
| 770 | Family Support Service Limit Exceeded |

Edit Listing for Providers

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|-----|---|
| 771 | Home Based Therapy Yearly Service Limit Exceeded |
| 772 | Day Treatment Limit Exceeded |
| 774 | Psychological Test With Report Limited to 12 Units Per Rolling Year |
| 775 | Neuro-Psychological Testing Yearly Service Limit Exceeded |
| 776 | Family Therapy is Limited to 20 Units Per Rolling 12 Months |
| 777 | Group Therapy is Limited to 20 Units Per Rolling 12 Months |
| 778 | Psychosocial Evaluation is Limited to 4 Hours Per Rolling Year |
| 779 | One Complete Visual Examination Covered in a 12 Month Period |
| 780 | Limit Two Lenses Per Rolling 12 Month Period |
| 781 | Limit One Frame Per Rolling 12 Month Period |
| 782 | Exceeded the Maximum EPSDT Screenings Allowed |
| 783 | Frames Billed Exceeds Service Limits Allowed and Has Been Cutback (EOB) |
| 784 | Psychiatric Evaluation Limited to 4 Units Per Rolling Year |
| 785 | Psychological Testing is Limited to 12 Units Per Rolling Year |
| 786 | Private Duty Nursing Not Allowed With Hospice Care |
| 787 | Maximum of 12 Therapeutic Leave Days Exceeded Per Rolling 12 Month Period |
| 789 | X-Ray Service Limit Exceeded For Calendar Year |
| 790 | X-Ray Service Limit Exceeded For Calendar Year |
| 791 | Manipulation Service Limit Exceeded For Calendar Year |
| 792 | Postpartum Care Cannot Exceed 60 Days From Delivery Date |
| 793 | Exceeds 12 Manipulations/Year L21 - PA Required |
| 795 | Suspended (Only) For Budget Funds |
| 796 | Claim Being Adjusted is Pended For Budget Relief |
| 798 | Void or Adjustment of Previously Voided or Adjusted Claim |
| 799 | Allowed Amount Less Than TPL& Co-Payment Amount |
| 800 | Duplicate of Previously Paid Claim |
| 801 | Duplicate of Previously Paid Claim |
| 802 | Duplicate of Previously Paid Claim |
| 803 | Duplicate of Previously Paid Claim |
| 804 | Duplicate of Previously Paid Claim |
| 805 | Duplicate of Previously Paid Claim |
| 806 | Duplicate of Previously Paid Claim |
| 807 | Duplicate of Previously Paid Claim |
| 808 | Duplicate of Previously Paid Claim |
| 809 | Duplicate of Previously Paid Claim |
| 810 | Duplicate of Previously Paid Claim |
| 811 | Duplicate of Previously Paid Claim |
| 812 | Duplicate of Previously Paid Claim |
| 813 | Duplicate of Previously Paid Claim |
| 814 | Duplicate of Previously Paid Claim |
| 815 | Duplicate of Previously Paid Claim |
| 816 | Duplicate of Previously Paid Claim |
| 817 | Duplicate of Previously Paid Claim |
| 818 | Duplicate of Previously Paid Claim |
| 819 | Duplicate of Previously Paid Claim |
| 820 | Duplicate of Previously Paid Claim |

Edit Listing for Providers

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| 821 | Duplicate of Previously Paid Claim |
| 822 | Duplicate of Previously Paid Claim |
| 823 | Duplicate of Previously Paid Claim |
| 824 | Duplicate of Previously Paid Claim |
| 825 | Duplicate of Previously Paid Claim |
| 826 | Duplicate of Previously Paid Claim |
| 827 | Duplicate of Previously Paid Claim |
| 828 | Duplicate of Previously Paid Claim |
| 829 | Duplicate of Previously Paid Claim |
| 830 | Duplicate of Previously Paid Claim |
| 831 | Duplicate of Previously Paid Claim |
| 832 | Duplicate of Previously Paid Claim |
| 833 | Duplicate of Previously Paid Claim |
| 834 | Duplicate of Previously Paid Claim |
| 835 | Duplicate of Previously Paid Claim |
| 836 | Duplicate of Previously Paid Claim |
| 837 | Duplicate of Previously Paid Claim |
| 838 | Duplicate of Previously Paid Claim |
| 839 | Duplicate of Previously Paid Claim |
| 840 | Duplicate of Previously Paid Claim |
| 841 | Duplicate of Previously Paid Claim |
| 842 | Duplicate of Previously Paid Claim |
| 843 | Duplicate of Previously Paid Claim |
| 844 | Duplicate of Previously Paid Claim |
| 845 | Duplicate of Previously Paid Claim |
| 846 | Duplicate of Previously Paid Claim |
| 847 | Duplicate of Previously Paid Claim |
| 848 | Duplicate of Previously Paid Claim |
| 849 | Duplicate of Previously Paid Claim |
| 850 | Duplicate of Previously Paid Claim |
| 851 | Duplicate of Previously Paid Claim |
| 852 | Duplicate of Previously Paid Claim |
| 853 | Service Not Allowed Same DOS as Institutional Care |
| 854 | Duplicate of Previously Paid Claim |
| 855 | Duplicate of Previously Paid Claim |
| 856 | Duplicate of Previously Paid Claim |
| 857 | Bilateral Surgery Duplicate |
| 858 | Duplicate of Previously Paid Claim |
| 859 | Home Infusion Therapy not Allowed with Another Home Infusion Therapy Service for Same Dates of Service |
| 860 | DME Home Infusion Therapy (HIT) Services Cannot be Paid with Concurrent Care across Service Programs |
| 861 | Service Previously Paid to Another Provider |
| 862 | Service Previously Paid to Another Provider |
| 863 | Service Previously Paid to Another Provider |
| 864 | Service Previously Paid to Another Provider |

Edit Listing for Providers

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|-----|---|
| 865 | Service Previously Paid to Another Provider |
| 866 | Service Previously Paid to Another Provider |
| 867 | Service Previously Paid to Another Provider |
| 868 | Service Previously Paid to Another Provider |
| 869 | Service Previously Paid to Another Provider |
| 870 | Service Previously Paid to Another Provider |
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| 873 | Service Previously Paid to Another Provider |
| 874 | Service Previously Paid to Another Provider |
| 875 | Service Previously Paid to Another Provider |
| 876 | Service Previously Paid to Another Provider |
| 877 | Service Previously Paid to Another Provider |
| 878 | Service Previously Paid to Another Provider |
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| 880 | Service Previously Paid to Another Provider |
| 881 | Service Previously Paid to Another Provider |
| 882 | Service Previously Paid to Another Provider |
| 883 | Service Previously Paid to Another Provider |
| 884 | Service Previously Paid to Another Provider |
| 885 | Service Previously Paid to Another Provider |
| 886 | Service Previously Paid to Another Provider |
| 887 | Service Previously Paid to Another Provider |
| 888 | Service Previously Paid to Another Provider |
| 889 | Service Previously Paid to Another Provider |
| 890 | Service Previously Paid to Another Provider |
| 891 | Service Previously Paid to Another Provider |
| 892 | Service Previously Paid to Another Provider |
| 893 | Service Previously Paid to Another Provider |
| 894 | Service Previously Paid to Another Provider |
| 895 | Service Previously Paid to Another Provider |
| 896 | Service Previously Paid to Another Provider |
| 897 | Service Previously Paid to Another Provider |
| 898 | Service Previously Paid to Another Provider |
| 899 | Service Previously Paid to Another Provider |
| 900 | Service Previously Paid to Another Provider |
| 901 | Service Previously Paid to Another Provider |
| 902 | Service Previously Paid to Another Provider |
| 903 | Service Previously Paid to Another Provider |
| 904 | Service Previously Paid to Another Provider |
| 905 | Duplicate of Previously Paid Claim |
| 906 | Duplicate of Previously Paid Claim |
| 907 | Service Previously Paid to Another Provider |
| 908 | Service Previously Paid to Another Provider |
| 909 | Service Previously Paid to Another Provider |
| 910 | Service Previously Paid to Another Provider |

Edit Listing for Providers

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| 911 | Service Previously Paid to Another Provider |
| 912 | Service Previously Paid to Another Provider |
| 913 | Service Previously Paid to Another Provider |
| 914 | Service Previously Paid to Another Provider |
| 915 | Service Previously Paid to Another Provider |
| 916 | Service Previously Paid to Another Provider |
| 917 | Concurrent Care with DME HIT Procedure Across Service Programs |
| 926 | Recipient Eligibility Rescinded by Public Assistance - Bill Recipient |
| 927 | EOB/Documentation Must Contain Description of Denied Services |
| 928 | Medicare EOB Says Not Medically Necessary; Rebill Medicare Correctly |
| 929 | Patient Has Medicare Coverage Retroactive To This Date of Service; Re-Bill Medicare |
| 930 | No Changes or Incorrect Changes Submitted on RTD |
| 931 | Recipient Under Age 21 When Consent Form Signed |
| 932 | Prior Authorization Request Has Been Denied |
| 933 | The Duplicate Edit is Bypassed Per Request of the Dental Consultant |
| 934 | Rebill as Medicare Crossover Claim (EOB) |
| 935 | More Than 180 Days Between Signature on Consent Form and Service (EOB) |
| 936 | Claim Denied; Rebill as Adjustment to Previously Paid Claim (EOB Only) |
| 937 | Medicare Denied Claim in Error; Re-Bill Medicare |
| 938 | EOB and/or Claim Altered; Resubmit Without Alteration |
| 939 | No Medicare Attachment; Bill Medicare |
| 940 | EOMB Shows Medicare Payment; Claim Must Be Billed as Crossover (EOB Only) |
| 941 | Information on Claim Conflicts With Supporting Documentation (EOB Only) |
| 943 | Services Denied By Medicare; Resubmit With Denial Reason on Valid EOMB (EOB Only) |
| 945 | Adjustment Denied - Insufficient Documentation (EOB Only) |
| 946 | Insufficient Medical Necessity Justification (EOB Only) |
| 947 | Written Explanation of Unlisted Procedure Not Sufficient For Approval (EOB Only) |
| 948 | Use Specific Code; Use of Unlisted Procedure Code Incorrect (EOB Only) |
| 949 | Rebill as Straight Medicaid With TPL Monies in Proper Field on Claim (EOB) |
| 950 | Compound Drug Billing Requires Ingredient List, Units, and Labor Time (EOB Only) |
| 951 | Per Your Request, This Claim is Being Denied (EOB Only) |
| 952 | Information on Claim Conflicts With Your Explanation of Benefits (EOB Only) |
| 953 | TPL/EOMB Denial Reason Not Valid For Payment by Medicaid |
| 954 | Re-Bill Insurance With Correct Patient/Policy Information |
| 955 | EOB States Provider Did Not Attempt To Pre-Authorize Service; Medicaid Cannot Pay |
| 956 | Gramm-Rudman Reduction Non-Covered (EOB Only) |
| 957 | Itemization is Insufficient/Incomplete (EOB) |
| 958 | EOB Not Valid; Must Show Entire Paid/Allowed/Denied Amount |
| 959 | Adjustment Denied – Paid According to Medicaid Guidelines |
| 960 | EOB Does Not Meet State Requirements |
| 961 | FHSC Cannot Authorize Travel or Accommodation Services |
| 963 | EOB Shows Payment By Other Insurance; Submit EOB From All Insurance Carriers |
| 962 | GRM Claims Require Itemization |
| 964 | Diagnosis Submitted Required Additional Documentation to Justify Need For Surgery (EOB) |
| 965 | Dispensing Fee Cutback - Only 1 Per Month Per N.H. Recipient |
| 966 | Insurance To Re-Process This Claim; Correspondence/Payment Will Go To Provider |

Edit Listing for Providers

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| 967 | EOB is Not For This Recipient |
| 968 | EOB is For Other Than This Date of Service |
| 969 | EOB is For Other Than This Service |
| 970 | Included in Fee For Office Visit |
| 971 | Included in Procedure/Item Fee |
| 972 | Multiple Surgery Payment Reduction |
| 973 | No Service Provided (EOB) |
| 974 | Insurance Denial of Payment Reason Must be Present on EOB |
| 975 | Included With Encounter Reimbursement |
| 976 | Insurance Preauthorization or Denial of Preauthorization Must Be Submitted With Claim |
| 977 | Insurance Needs More Information; Comply Then Rebill Medicaid |
| 978 | EOB Shows TPL Payment; Claim Shows No TPL Amount |
| 979 | Policy With Billed Insurance Has Terminated; Bill New Insurance |
| 980 | Consent Form Does Not Meet State Guidelines |
| 981 | Rebill VA After Patient Has Renewed VA Eligibility |
| 982 | Certification of Medical Necessity For Abortion Does Not Meet Guidelines |
| 983 | Certification of Medical Necessity For Abortion Required For Procedure |
| 984 | Consent Form Must Be Signed By Recipient |
| 985 | Consent Form Must Be Signed By Physician |
| 986 | Consent Form Must Be Signed in Obtainer's Own Handwriting |
| 987 | Consent Form Must Be Signed By Witness |
| 988 | Alternative Paragraph on Consent Form Must Be Marked as Instructed |
| 989 | Minimum of 30 Days Between Sterilization Consent Sign and Surgery Not Met |
| 990 | Physician's Statement Incomplete |
| 991 | Diagnosis Not Listed in ICD 9 Text |
| 992 | Incorrect Date of Birth - Sterilization Related |
| 993 | Additional Digits Required For Diagnosis |
| 994 | Patient's Date of Birth Missing on Sterilization Consent Form (EOB Only) |
| 995 | Surgery Date on Claim Different From Surgery Date on Consent Form (EOB) |
| 996 | Patient Statement Incomplete (EOB Only) |
| 997 | VA Preauthorization or Denial of Preauthorization, For This Service, Must Accompany Claim |
| 998 | Out of State Claim Awaiting Pricing Information |
| 999 | This Claim Has Too Many Claims Extracted From the History File |