



NJMMIS Edit Codes/HIPAA Edit Codes Translation -
 Sequenced by HIPAA Adj Reason Code
 Last Date Loaded - 3/1/2026

HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
		2173	INCORRECT PRESCRIBER DEA#/NPI# SUBMITTED		
3 (10/16/03)	Co-payment Amount	0941	SENIOR GOLD CO-PAY APPLIED FROM VOIDED CLAIM	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
3 (04/01/18)	Co-payment Amount	1625	COMMERCIAL HMO CO-PAY/COINS/DEDUCT	MA80 (04/01/18)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0162	INV/MISS PROCEDURE CODE MODIFIER	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0163	PROCEDURE - SPANNING DATES OF SERVICE	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0168	MISSING MANDATORY PROCEDURE CODE MODIFIER	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0169	INVALID MODIFIER FOR PROC CODE,CLM TYPE OR SERVICE DATE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0232	'YD' OR 'UD' MODIFIER NOT ALLOWED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0241	22 MOD SERVICES NOT JUSTIFIED/PAID AT UNMODIFIED RATE	N657 (11/01/15)	This should be billed with the appropriate code for these services.



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4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0256	PROCEDURE MODIFIER REQUIRED	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0267	PROCEDURE CODE DOES NOT WARRANT ANESTHESIA SERVICES	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
4 (11/01/15)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0519	MODIFIER ADDED - TRIP OVER 15 MILES	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
4 (10/16/03)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0584	MODIFIER REMOVED - TRIP LESS THAN 16 MILES	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0589	MODIFIER NOT ALLOWED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0860	PROCEDURE CODE MODIFIERS IN CONFLICT	N519 (01/01/14)	Invalid combination of HCPCS modifiers.
4 (01/01/14)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1204	ANESTHESIA SERV NOT PAYABLE-SURG PROC WITH AA MOD REQ	N572 (01/01/14)	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.
4 (06/18/07)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1834	CLAIM CHECK: INVALID MODIFIER	N519 (01/01/14)	Invalid combination of HCPCS modifiers.



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4 (12/01/22)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1856	CLAIMSXTEN: MISSING MODIFIER 26	N822 (12/01/22)	Missing procedure modifier(s).
4 (01/29/16)	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2231	BENEFIT STAGE AMOUNT IS NOT NUMERIC		
5 (11/01/15)	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1314	HOSPICE PROCEDURE/PLACE OF SERVICE RESTRICTION	M77 (11/01/15)	Missing/incomplete/invalid/inappropriate place of service.
6 (01/01/14)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0254	PROCEDURE CODE NDC AGE RESTRICTED	N129 (11/01/15)	Not eligible due to the patient's age.
6 (11/01/15)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0351	RECIP AGE AT THE TIME OF STERILIZATION CONSENT DTE < 21	N129 (11/01/15)	Not eligible due to the patient's age.
6 (01/01/21)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1705	DOULA VISIT EXCEEDS AGE LIMIT	N129 (01/01/21)	Not eligible due to the patient's age.
6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1824	CLAIM CHECK: AGE CANNOT BE GREATER THAN 124 YEARS	N329 (12/12/07)	Missing/incomplete/invalid patient birth date.
6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1825	CLAIM CHECK: PROCEDURE INDICATED FOR NEONATE PATIENT	N129 (01/01/14)	Not eligible due to the patient's age.



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6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1826	CLAIM CHECK: PROCEDURE INDICATED FOR PEDIATRIC PATIENT	N129 (01/01/14)	Not eligible due to the patient's age.
6 (12/12/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1827	CLAIM CHECK: PROCEDURE INDICATED FOR MATERNITY PATIENT	N129 (01/01/14)	Not eligible due to the patient's age.
6 (06/18/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1828	CLAIM CHECK: PROCEDURE INDICATED FOR ADULT PATIENT	N129 (01/01/14)	Not eligible due to the patient's age.
6 (06/18/07)	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1881	CLAIM CHECK: PROCEDURE CODE AGE RESTRICTED	N129 (01/01/14)	Not eligible due to the patient's age.
7 (12/12/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1803	CLAIM CHECK: INVALID OR MISSING GENDER	MA39 (06/18/07)	Missing/incomplete/invalid gender.
7 (06/18/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1831	CLAIM CHECK: PROCEDURE NOT INDICATED FOR A FEMALE	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
7 (06/18/07)	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1893	CLAIM CHECK: PROCEDURE GENDER RESTRICTION	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0125	THIS PROVIDER INVALID WITH MODIFIER UE OR U6 OR WI OR WR	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0202	PROVIDER CANNOT SUBMIT THIS CLAIM TYPE	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0237	PROCEDURE/PROVIDER SPECIALTY RESTRICTION	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0278	PROVIDER NOT AUTHORIZED THIS PROCEDURE	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0380	CLAIM SUBMITTED FFS - SERVICE IS IN-PLAN (MANAGED CARE)	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
8 (11/01/15)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0381	CLAIM SUBMITTED FFS-UNABLE TO DETERMINE IN-PLAN/OUT-OF-PLAN	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
8 (10/16/03)	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0590	PROC CODE BILLED IS ONLY PAYABLE TO A SPECIALIST	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
9 (01/01/14)	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0479	PRIV PSYCH HOSP - LTC-PAT AGE > 21 AND < 65	N517 (01/01/14)	Resubmit a new claim with the requested information.
9 (05/21/12)	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1303	MENTAL HEALTH SERVICE UNDER 2 NOT COVERED	N657 (11/01/15)	This should be billed with the appropriate code for these services.
10 (01/01/14)	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0293	DIAGNOSIS NOT ALLOWED FOR SEX	N517 (01/01/14)	Resubmit a new claim with the requested information.



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10 (01/01/16)	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2112	CONFLICTING GENDER CODE - CONFIRM GENDER AND BENE ID NUMBER		
11 (10/16/03)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0923	DAILY DOSAGE LESS THAN MINIMUM RECOMMENDED DOSAGE	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
11 (11/01/15)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1378	FQHC MENTAL HEALTH/MEDICAL PROC/DIAG MISMATCH	N657 (11/01/15)	This should be billed with the appropriate code for these services.
11 (01/29/16)	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2227	DIAGNOSIS CODE QUALIFIER VALUES ARE NOT EQUAL		
14 (10/16/03)	The date of birth follows the date of service.	0401	DATE OF SERVICE < DATE OF BIRTH	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
14 (01/01/16)	The date of birth follows the date of service.	2113	CONFLICTING DATE OF BIRTH - CONFIRM DOB AND BENE ID NUMBER		
15 (01/01/14)	The authorization number is missing, invalid, or does not apply to the billed services or provider.	0411	GSHP PRIOR AUTHORIZATION NOT REQUIRED..	N517 (01/01/14)	Resubmit a new claim with the requested information.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0001	GENERIC ELIGIBILITY RECORD USED.	MA43 (11/01/15)	Missing/incomplete/invalid patient status.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0002	BILLING PROVIDER NUMBER MISSING/INVALID	N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0005	INV/MISS ATTENDING PHYSICIAN MEDICAID ID NUMBER	N253 (01/15/13)	Missing/incomplete/invalid attending provider primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0006	INVALID REFERRING/OTHER PROVIDER IDENTIFIER	N270 (01/01/14)	Missing/incomplete/invalid other provider primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0007	BILLING PROVIDER CHECK DIGIT INVALID	N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.



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16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0011	RECIPIENT NUMBER MISSING OR INVALID	N382 (02/01/19)	Missing/incomplete/invalid patient identifier.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0012	MISSING RECIPIENT NAME	MA36 (10/16/03)	Missing/incomplete/invalid patient name.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0013	INVALID BIRTHDATE	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0015	STATEMENT THRU DATE < STATEMENT FROM DATE	M59 (11/01/15)	Missing/incomplete/invalid 'to' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0016	INV/MISS SERVICE FROM DATE	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0017	INV/MISS SERVICE THRU DATE	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0020	SERVICE THRU DATE > DATE RECEIVED - VERIFY SERVICE THRU DATE	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0022	INV/MISS BILLED DATE	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0024	POS REVERSAL REJECTED-RESUBMIT USING FD-999 FORM.	N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0025	INV/MISS DISPENSED DATE	N57 (10/16/03)	Missing/incomplete/invalid prescribing date.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0031	CONDITION CODE 85/C3 PRESENT, REQUIRES REVENUE CODE 912	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0033	SUBMITTER ID IS NOT NUMERIC OR = "O".	N407 (11/01/15)	You are not an approved submitter for this transmission format.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0034	MISSING LABORATORY SERVICE REVENUE CODE	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0035	HOSPICE CLAIM - NUMBER OF UNITS NOT EQUAL TO NUMBER OF DAYS	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0036	INVALID ACUTE DAYS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0037	INVALID SNF DAYS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0038	INVALID ICF DAYS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0039	INVALID RESIDENTIAL DAYS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0040	INV/MISS ADMISSION DATE	MA40 (10/16/03)	Missing/incomplete/invalid admission date.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0041	ADMISSION DATE > SERVICE COVERS FROM DATE	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0042	INV/MISS TYPE BILL CODE	N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0044	INV/MISS TYPE OF ADMISSION	MA41 (10/16/03)	Missing/incomplete/invalid admission type.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0045	INV/MISS PATIENT STATUS CODE	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0046	TOTAL DAYS NOT EQUAL TO DATES OF SERVICE	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0048	MISSING/INV SURGICAL PROCEDURE CODE	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0049	INV/MISS SURG DATE - SUPPLY VALID DATE OR REMOVE PROC CODE	N341 (01/01/14)	Missing/incomplete/invalid surgery date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0050	BLOOD NOT REPLACED AMOUNT MUST BE NUMERIC	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0051	RENAL REVENUE IS PRESENT - RENAL BILL TYPE IS MISSING	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0052	TOTAL BLOOD PINTS FURNISHED INCORRECT	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0053	INV/MISS ACCOMMODATION DAYS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0054	INPATIENT/INPATIENT CROSSOVER CLAIM - SWING BEDS	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0055	A 1 IS NOT PRESENT IN THE PA IND FIELD AND PA # IS PRESENT	M62 (11/01/15)	Missing/incomplete/invalid treatment authorization code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0056	INV/MISS REVENUE UNITS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0057	CONDITION CODE 40 - FROM/THRU NOT EQUAL	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0060	INV/MISS OCCURENCE CODE - SUPPLY VALID CODE OR REMOVE DATE	M45 (11/01/15)	Missing/incomplete/invalid occurrence code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0062	INVALID CONDITION CODE	M44 (01/01/14)	Missing/incomplete/invalid condition code.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0063	INV/MISS ADMISSION HOUR	N46 (10/16/03)	Missing/incomplete/invalid admission hour.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0064	SERVICE THRU DATE > STATEMENT THRU DATE	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0065	PINTS OF BLOOD FURNISHED MUST BE NUMERIC	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0066	INVALID SPECIAL PROGRAM INDICATOR	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0067	INV/MISS NON COVERED HOSPITAL DAYS	MA33 (10/16/03)	Missing/incomplete/invalid non-covered days during the billing period.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0068	INVALID SOURCE OF ADMISSION	MA42 (10/16/03)	Missing/incomplete/invalid admission source.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0069	INVALID OCCURENCE DATE	N300 (01/01/14)	Missing/incomplete/invalid occurrence span date(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0071	INVALID STATEMENT COVERS FROM DATE	M52 (10/16/03)	Missing/incomplete/invalid 'from' date(s) of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0072	INVALID STATEMENT COVERS THRU DATE	M59 (10/16/03)	Missing/incomplete/invalid 'to' date(s) of service.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0073	SERVICE COVERS FROM DATE < STATEMENT FROM DATE	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0074	STATEMENT COVERS FROM DATE > SERVICE THRU DATE	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0075	PINTS OF BLOOD REPLACED NOT NUMERIC	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0079	INPATIENT CLAIM-REQUIRES AT LEAST ONE ACCOMMODATION REV CODE	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0080	ICN DATE IS > 2 YRS FROM SERVICE DATE	M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0081	INV/MISS CLINIC CODE	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0082	EMERG ROOM REV CODE (S) PRESENT - CLINIC CODE '00' MISSING	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0083	REV CODE 099,36X,37X,49X OR 71X REQ VALID SURGICAL PROC	N657 (11/01/15)	This should be billed with the appropriate code for these services.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0084	BABY & MOTHER-ADMIT SOURCE INVALID FOR ADMIT TYPE (NEWBORN)	MA42 (10/16/03)	Missing/incomplete/invalid admission source.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0085	INV/MISS DAYS/UNITS/VISITS	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0086	NUMBER OF UNITS EXCEEDS MONTHS/DAYS OF SERVICE	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0087	CLAIM INDICATES SURGERY - SURGEON NUMBER MISSING	N247 (11/01/15)	Missing/incomplete/invalid assistant surgeon taxonomy.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0089	DATE OF SURGERY > SERVICE/STATEMENT THRU DATE	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0091	INV/MISS EPSDT LABORATORY INDICATOR	M126 (01/01/14)	Missing/incomplete/invalid individual lab codes included in the test.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0100	ORIGINAL RECIPIENT ID HAS BEEN CHANGED DUE TO LINK/UNLINK	N382 (11/01/15)	Missing/incomplete/invalid patient identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0101	ABNOR INDIC IN THE PHYS/SCR IND NEW/PRIOR COND INVAL/MISS	N27 (11/01/15)	Missing/incomplete/invalid treatment number.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0102	INV/MISS TOOTH SURFACE	N75 (01/01/14)	Missing/incomplete/invalid tooth surface information.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0106	CONSECUTIVE LEAVE TYPES-OVERLAPPING DATES OF SERVICES	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0109	ALLOWABLE AMOUNT IS LESS THAN CO-PAY AMOUNT	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0111	LIVERY CLAIM FILED > 90 DAYS AFTER SERVICE	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0113	LTC/HOSPICE LONG TERM PSYCH CLAIM SPANS MONTHS'	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0114	INV/MISS ADMIT CODE	MA65 (10/16/03)	Missing/incomplete/invalid admitting diagnosis.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0115	INVALID GENERAL STATUS / DISCHARGE CODE	N50 (10/16/03)	Missing/incomplete/invalid discharge information.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0119	INV/MISS LEAVE OF ABSENCE CODE	N50 (10/16/03)	Missing/incomplete/invalid discharge information.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0123	EMC CLM NOT ALLOWED FOR SR GOLD CLM SUBMIT BY POS	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0127	NDC CODE MISSING OR INVALID	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0128	CLAIM > \$400-RESUB CLAIM VERIFYING METRIC QUANTITY REPORTED	N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0129	INVALID ATTACHMENT CODE GREATER THAN 17	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0130	INV/MISS DAYS SUPPLY	M123 (11/01/15)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0131	INV/MISS PRESCRIPTION NUMBER	N388 (11/01/15)	Missing/incomplete/invalid prescription number.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0132	INV/MISS NURSING FACILITY (LTCF) INDICATOR	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0134	USE PROPER PROCEDURE CD. SEE NEWSLTR VOL 2 #61 DATED 11/92	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0135	INV/MISS CURRENT EXAM DATE	N301 (11/01/15)	Missing/incomplete/invalid procedure date(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0136	COPAY CLAIM DENIED - NO BENEFICIARY OR PROGRAM LIABILITY	N58 (11/01/15)	Missing/incomplete/invalid patient liability amount.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0137	CURRENT EXAM GREATER THAN DATE DISPENSED	N304 (11/01/15)	Missing/incomplete/invalid dispensed date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0138	ACCIDENT INDICATOR MUST BE Y, N, OR SPACE	N657 (11/01/15)	This should be billed with the appropriate code for these services.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0139	EPSDT INDICATOR NOT Y, N OR SPACE	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0140	LABORATORY INDICATOR MUST BE Y OR N	MA110 (08/31/04)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0141	INV/MISS PLACE OF SERVICE	M77 (01/01/14)	Missing/incomplete/invalid/inappropriate place of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0142	INV/MISS ORIGIN CODE	N657 (11/01/15)	This should be billed with the appropriate code for these services.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0143	INV/MISS DESTINATION CODE	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0147	FAMILY PLANNING INDICATOR MUST BE Y OR N	N554 (11/01/15)	Missing/Incomplete/Invalid Family Planning Indicator.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0149	CONTINUOUS HOME CARE BILLED LESS THAN 8 HOURS	N430 (11/01/15)	Procedure code is inconsistent with the units billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0150	INVALID PROCEDURE CODE FOR EPSDT FORM - REBILL ON 1500NJ	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0151	INV/MISS CLAIM LINE CHARGE(S)	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0152	INV/MISS TOTAL CHARGE	M54 (10/16/03)	Missing/incomplete/invalid total charges.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0153	INCORRECT TOTAL CHARGES	M54 (10/16/03)	Missing/incomplete/invalid total charges.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0154	COINS AND/OR LIFETIME RESERVE DAYS CONFLICT WITH DOS	MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0155	COINS DAYS LIFETIME RESERVE DAYS AND/OR BLD DEDUCT MISSING	MA35 (10/16/03)	Missing/incomplete/invalid number of lifetime reserve days.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0156	COINSURANCE DAYS AND/OR LIFETIME RESERVE DAYS NOT NUMERIC	MA35 (11/01/15)	Missing/incomplete/invalid number of lifetime reserve days.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0157	ACUTE DAYS > 150 - RESUBMIT AS INPATIENT TPL CLAIM	MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0158	ACUTE DAYS > 90 - RESUBMIT AS INPATIENT TPL CLAIM	MA32 (10/16/03)	Missing/incomplete/invalid number of covered days during the billing period.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0160	INVALID ANESTHESIA CLAIM - CORRECT PROCEDURE AND UNITS	N440 (11/01/15)	Incomplete/invalid anesthesia physical status report/indicators.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0161	INV/MISS HCPCS PROCEDURE CODE	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0165	EMC - INVALID HCPCS PROCEDURE PREFIX	M20 (10/16/03)	Missing/incomplete/invalid HCPCS.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0166	INV/MISS DIAGNOSIS CODE	M76 (01/01/14)	Missing/incomplete/invalid diagnosis or condition.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0167	MISSING PRIMARY DIAGNOSIS CODE	M76 (01/01/14)	Missing/incomplete/invalid diagnosis or condition.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0170	EXCESSIVE ANESTHESIA UNITS - PEND FOR MEDICAL REVIEW	N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/units.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0171	INVALID CARRIER CODE	N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0172	INVALID PAYOR ID	M56 (10/16/03)	Missing/incomplete/invalid payer identifier.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0173	INVALID COINSURANCE DAYS	MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0174	CLAIM IS NOT XOVER - RESUBMIT AS INPATIENT HOSPITAL CLAIM	N8 (10/16/03)	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0175	BLOOD DEDUCTIBLE CHARGES MUST BE NUMERIC	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0176	MCARE DEDUCTIBLE AMOUNT MUST BE NUMERIC	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0177	MCARE COINSURANCE AMOUNT MUST BE NUMERIC	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0178	BLOOD DEDUCTIBLE (PINTS) MUST BE NUMERIC	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0179	MISSING/INVALID COINSURANCE DAYS	MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0180	OTHER INSURANCE INDICATOR MUST BE Y OR N	MA112 (01/01/14)	Missing/incomplete/invalid group practice information.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0181	TOTAL TPL AMOUNT MUST BE NUMERIC	M49 (10/16/03)	Missing/incomplete/invalid value code(s) or amount(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0182	OVERRIDE CODE NOT NUMERIC	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0183	MEDICARE PAYMENT DATE IS MISSING OR INVALID	N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0184	INVALID/MISSING ADJUSTMENT REASON	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).



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16 (01/01/13)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0186	MEDICARE ALLOWED NOT NUMERIC OR NOT > ZERO	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0187	DEDUCTIBLE, BLOOD DEDUCTIBLE, AND/OR COINSURANCE AMT MISSING	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0188	CASH DEDUCTIBLE AMOUNT EXCEEDS THE YEARLY MAXIMUM	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0189	EXPIRATION OF CCF TIME LIMIT OR NO CHANGE INDICATED ON CCF	N299 (11/01/15)	Missing/incomplete/invalid occurrence date(s).



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0190	1ST 2 POSITIONS OF BILL TYPE CONFLICTS WITH THE PAYOR ID	MA30 (11/01/15)	Missing/incomplete/invalid type of bill.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0192	MEDICAID NOT PRIMARY PAYOR SINCE TPL AMOUNT > ZERO	MA04 (11/01/15)	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0193	MEDICAID CHARGES PLUS TPL AMOUNT < 50% BILLED CHARGES	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0194	MISSING MEDICAID CHARGES	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0195	CORRECT UNITS-15 MINUTES ANESTHESIA TIME = 1 UNIT OF SERVICE	N203 (11/01/15)	Missing/incomplete/invalid anesthesia time/units.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0198	VERIFY AND/OR CORR DRG CODE	N208 (11/01/15)	Missing/incomplete/invalid DRG code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0200	ATTENDING PHYSICIAN NOT ON FILE	N253 (01/01/14)	Missing/incomplete/invalid attending provider primary identifier.
16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0204	SERVICING AND BILLING PROVIDERS NOT LINKED ON D.O.S.	N257 (02/01/19)	Missing/incomplete/invalid billing provider/supplier primary identifier.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0205	SERVICING PROVIDER IS GROUP PROVIDER	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0206	BILLING PROVIDER NOT ON FILE	N257 (01/01/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0208	PROVIDER APPROVED FOR EMC ONLY	M77 (11/01/15)	Missing/incomplete/invalid/inappropriate place of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0209	GROUP MUST BILL FOR MEMBER OF GROUP	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0211	SERVICING PROVIDER IS GROUP-GROUP HAS NO MEMBERS	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0218	REFERRING/OTHER PHYSICIAN PROVIDER NOT ON FILE	N269 (01/01/14)	Missing/incomplete/invalid other provider name.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0220	CLAIM SPANS FISCAL YEAR	MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0224	PRESCRIBING PHYSICIAN/PRACTIONER NUMBER NOT ON FILE	N265 (01/01/14)	Missing/incomplete/invalid ordering provider primary identifier.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0225	BILLING PROVIDER IS NOT A GROUP	MA112 (11/01/15)	Missing/incomplete/invalid group practice information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0227	PROVIDER NOT APPROVED FOR EMC	N407 (11/01/15)	You are not an approved submitter for this transmission format.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0230	BILLING OR SERVING PROVIDER NOT VALID	N257 (11/01/15)	Missing/incomplete/invalid billing provider/supplier primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0231	REFERRING PROVIDER NUMBER REQUIRED - GSHP	N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0235	INVALID DIVISION OF JUVENILE SERVICES CLAIM.	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0238	PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT	N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0247	REVENUE/ICD9/HCPCS PROC CODE ON CLM CONFLICTS WITH CLM TYPE	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0248	SURGERY PROCEDURE CODE NOT ON FILE	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0252	PROC/REVENUE CODE/NDC/DIAG REQUIRES REVIEW	M119 (01/01/14)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0257	PROC/NDC/REV/ICD NOT CVRD BY MA, MA-RELATED, PAAD/SR GOLD	M50 (01/01/14)	Missing/incomplete/invalid revenue code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0258	AMBULATORY SURGICAL CENTER-DAYS/DATES INCONSISTENT	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0259	HCPCS PROCEDURE CODE NOT ON FILE	M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0260	DIAGNOSTIC REPORT (XRAYS,LAB,ETC.) REQUESTED	MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0262	REFER/OTHER PHY REQ FOR CONSULT AND/OR 2ND OPINION	N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0265	SERVICE NOT PAYABLE TO ASC	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0271	SUBMITTER NOT APPROVED FOR PROVIDER.	N407 (11/01/15)	You are not an approved submitter for this transmission format.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0272	USE PROPER PRO CODE -SEE NEWSLETTER VOL.2 #61 DATED 11/92	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0273	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST	N56 (11/01/15)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0275	RADIOLOGY SERVICES REQUIRE REFERRING PHYSICIAN	N285 (11/01/15)	Missing/incomplete/invalid referring provider name.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0277	REFERRING PROVIDER NUMBER REQUIRED	N286 (01/01/14)	Missing/incomplete/invalid referring provider primary identifier.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0283	PROVIDER LIMITED TO NON-DYFS BENEFICIARIES	M62 (11/01/15)	Missing/incomplete/invalid treatment authorization code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0284	PRIVATE DUTY NURSING - SPANNING DATES OF SERVICE	N62 (01/01/14)	Dates of service span multiple rate periods. Resubmit separate claims.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0288	VETERANS HOME RESIDENT, NON COVERED SERVICE	N34 (11/01/15)	Incorrect claim form/format for this service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0290	INVALID SECONDARY DIAGNOSIS	M64 (10/16/03)	Missing/incomplete/invalid other diagnosis.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0294	DIAGNOSIS NOT VALID AS PRIMARY DIAGNOSIS	MA63 (11/01/15)	Missing/incomplete/invalid principal diagnosis.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0295	INVALID THIRD OR SUBSEQUENT DIAGNOSIS.	M64 (01/01/14)	Missing/incomplete/invalid other diagnosis.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0297	SERVICE PROVIDER NOT ENROLLED IN CLIA	MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification number.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0298	SERVICE PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE	MA120 (01/01/14)	Missing/incomplete/invalid CLIA certification number.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0302	NAME MISMATCH OR FOR PHARMACY: GENDER AND/OR DOB	MA36 (01/01/14)	Missing/incomplete/invalid patient name.
16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0306	MEDICAID RECIP ID CORRECTED	N382 (01/01/16)	Missing/incomplete/invalid patient identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0311	CORRECT D.O.B. OR RESUBMIT CLAIM UNDER BABY'S NUMBER	N329 (11/01/15)	Missing/incomplete/invalid patient birth date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0312	CORRECT RECIPIENT NUMBER AND RESUBMIT	MA27 (11/01/15)	Missing/incomplete/invalid entitlement number or name shown on the claim.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0314	CLAIM SERV. DATES OVERLAP SPEC. PROG. ELIG. BEGIN/END DATES.	N443 (01/01/14)	Missing/incomplete/invalid total time or begin/end time.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0319	INCORRECT/MISSING MEDICALLY NEEDY TRANSMITTAL FORM	N61 (11/01/15)	Rebill services on separate claims.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0321	RECIPIENT NOT ON FILE	N382 (11/01/15)	Missing/incomplete/invalid patient identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0322	HMO COVERED SERVICE -REVIEW REQUIRED	M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0325	SERVICE NOT COVERED BY HMO - RECIPIENT INELIG FOR MEDICAID	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0326	LTC RECIPIENT NOT ON FILE	N147 (11/01/15)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0328	MHC RECIPIENT-NO M'CAID ELIG SEGMENT FOR THIS PERIOD	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0330	HYSTERECTOMY DID NOT MEET PROGRAM REQUIREMENTS	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.



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16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0331	SECOND OPINION REQUIRED	N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0333	INVALID/MISSING SECOND OPINION INDICATOR	N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0334	DATE OF CONS MUST BE AT LEAST 30 BUT NOT > 180 DAYS FROM DOS	MA31 (11/01/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0339	DENY SECOND OPINION NOT OBTAINED	N286 (04/01/18)	Missing/incomplete/invalid referring provider primary identifier.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0340	ABORTION CERT FORM DATA INCORRECT/MISSING OR ILLEGIBLE	N34 (11/01/15)	Incorrect claim form/format for this service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0342	RECIPIENT DATES, SIGNATURE MISSING ON HYSTER FORM	MA75 (01/01/14)	Missing/incomplete/invalid patient or authorized representative signature.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0343	INVALID/MISS STERILIZATION CONSENT DATE	MA100 (11/01/15)	Missing/incomplete/invalid date of current illness or symptoms.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0344	PHYSICIAN SIGN/NUMBER/DATES MISSING ON ABORTION FORM	MA81 (01/01/14)	Missing/incomplete/invalid provider/supplier signature.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0345	MISSING ABORTION PROCEDURE CODE	MA66 (10/16/03)	Missing/incomplete/invalid principal procedure code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0346	INVALID/MISSING STERILIZATION INTERPRETER INDICATOR	MA58 (11/01/15)	Missing/incomplete/invalid release of information indicator.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0347	INVALID/MISS STERILIZATION RACE CODE	MA58 (11/01/15)	Missing/incomplete/invalid release of information indicator.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0348	INVALID ABORTION CODE	N27 (11/01/15)	Missing/incomplete/invalid treatment number.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0356	RECIP/PHYS DATE/SIGN MISSING ON STERILIZATION FORM	MA71 (11/01/15)	Missing/incomplete/invalid provider representative signature date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0357	HYSTERECTOMY RECEIPT OF INFO FORM-DATA INCORR/MISS OR ILLEG	N34 (01/01/14)	Incorrect claim form/format for this service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0360	PHYSICIAN SIGNATURE/DATE MISSING ON SECOND OPINION FORM	MA70 (01/01/14)	Missing/incomplete/invalid provider representative signature.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0361	INSUFFICIENT MEDICAL DOCUMENTATION FOR HYSTERECTOMY	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0362	CLAIM IS POSSIBLE STERILIZATION	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0363	CLAIM IS POSSIBLE ABORTION	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0364	CLAIM SPANS HMO ENROLLMENT - CALL REVS	N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0367	GA RECIPIENT INELIGIBLE ON DATE OF SERVICE	MA43 (10/16/03)	Missing/incomplete/invalid patient status.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0374	REPORTED SERVICE UNITS MUST BE GREATER THAN 1 & LESS THAN 6	M53 (02/02/04)	Missing/incomplete/invalid days or units of service.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0383	DATE OF SERVICE LATER THAN DATE OF DEATH	N330 (11/01/15)	Missing/incomplete/invalid patient death date.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0384	DATE OF SERVICE LATER THAN DATE OF DEATH	N330 (11/01/15)	Missing/incomplete/invalid patient death date.
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0408	PRIOR AUTHORIZATION NUMBER INVALID	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0412	GSHP QA/QU PRIOR AUTHORIZATION REQUIRED	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0419	WFNJ/GA OR NJFL CLAIM PROCESSED AS ADDP	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0420	CLAIM PAYABLE UNDER WFNJ/GA OR FC ONLY	MA43 (10/16/03)	Missing/incomplete/invalid patient status.
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0422	MANAGED CARE RECIPIENT-PRIOR AUTHORIZATION REQUIRED	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0423	PRIOR AUTHORIZATION REQUIRED	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0430	OTHER COVERAGE CODE VALUE IS INVALID	N245 (09/01/20)	Incomplete/invalid plan information for other insurance.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0435	UNABLE TO DETERMINE HIPAA CLAIM TYPE.	MA30 (10/16/03)	Missing/incomplete/invalid type of bill.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0437	INVALID SUBMITTED ID	N407 (11/01/15)	You are not an approved submitter for this transmission format.



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16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0443	TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT	MA92 (09/01/20)	Missing plan information for other insurance.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0457	LTC FACILITY ID MISSING ON POS REBILL UNIT DOSE RESTOCK	M44 (10/16/03)	Missing/incomplete/invalid condition code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0461	ESRD CLAIM-OCCURRENCE CODE 35 REQUIRED	M45 (10/16/03)	Missing/incomplete/invalid occurrence code(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0462	RENAL REVENUE CODE PRESENT - RENAL CONDITION CODE REQUIRED	M44 (10/16/03)	Missing/incomplete/invalid condition code.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0472	FQHC ENCOUNT BILLED UNITS GT PAID HCPCS UNITS ON HIST	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0473	TOTAL CALCULATED CHARGE NOT EQUAL TO TOTAL BILLED CHARGE	M54 (10/16/03)	Missing/incomplete/invalid total charges.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0474	NET CALCULATED CHARGES NOT EQUAL TO NET BILLED CHARGE	M54 (10/16/03)	Missing/incomplete/invalid total charges.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0496	INVALID BIRTH WEIGHT / DRG	N207 (11/01/15)	Missing/incomplete/invalid weight.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0499	ACUTE DAYS BILLED EQUAL ZERO	N306 (11/01/15)	Missing/incomplete/invalid acute manifestation date.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0503	REVENUE CODE NOT ON FILE	M50 (10/16/03)	Missing/incomplete/invalid revenue code(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0508	PROVIDER NOT MEDICARE CERTIFIED - BED HOLD NOT ALLOWED	MA96 (11/01/15)	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0510	COINS DAYS MUST BE BILLED PRIOR TO LIFETIME RESERVE DAYS	MA34 (10/16/03)	Missing/incomplete/invalid number of coinsurance days during the billing period.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0513	LTC CROSSOVER CLAIM REQUIRES A MEDICARE PER DIEM RATE	N147 (01/01/14)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0514	NURSING FACILITY LEAVE/RETURN RESTRICTED	N50 (10/16/03)	Missing/incomplete/invalid discharge information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0515	NURSING FACILITY ADMIT RESTRICTED	MA40 (11/01/15)	Missing/incomplete/invalid admission date.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0522	INCORRECT PROVIDER FOR LTC SPECIAL PROGRAM	N32 (11/01/15)	Claim must be submitted by the provider who rendered the service.



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16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0542	NON-LEGEND DRUG NOT PAYABLE FOR DATE OF SERVICE	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0549	DRUG NOT PAYABLE - NO REBATE AGREEMENT		
16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0551	NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0553	COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0559	COMPOUND DRUG-NDC CODE MISSING OR INVALID	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0560	COMPOUND DRUG-QUANTITY MISSING OR INVALID	M123 (10/16/03)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0574	CAPITATION RATE NOT FOUND FOR CLAIM DOS	N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0575	NO GSHP PCM RATE NOT FOUND FOR CLAIM SERVICE DATE	N65 (11/01/15)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.



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16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0577	PA REQUIRED FOR WFNJ/GA DRUG COVERAGE	M62 (09/01/20)	Missing/incomplete/invalid treatment authorization code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0579	PROVIDER IRS NUM REQUIRED FOR SPECIAL EDUC CLAIM	N77 (11/01/15)	Missing/incomplete/invalid designated provider number.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0580	CLAIM ERROR REASONS > 10	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0582	MISSING/INVALID TOOTH SURFACE	N75 (10/16/03)	Missing/incomplete/invalid tooth surface information.



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16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0585	SERVICE UNITS INCONSISTENT WITH PRODUCT PACKAGING	M53 (09/01/20)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0586	MISSING/INVALID TOOTH QUADRANT	N75 (11/01/15)	Missing/incomplete/invalid tooth surface information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0587	MISSING/INVALID TOOTH NUMBER	N37 (11/01/15)	Missing/incomplete/invalid tooth number/letter.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0588	OTHER PAYER CHGS ARE MISSING VALUE CODE 24 AND AMOUNT REQ	M54 (01/01/14)	Missing/incomplete/invalid total charges.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0591	PROVIDER NOT ON PROVIDER RATE FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0592	CAPITATION CATEGORY NOT ON GSHP RATE FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0594	CLAIM NOT ELIGIBLE FOR ADD-ON DATE OF SERVICE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0595	REV CODE/COND CODE CONFLICT FOR COMPOSITE RATE PRICING	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0596	PHARMACY CAPITATION RATE LEVEL NOT IN EFFECT FOR DOS	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0599	INVALID LTC COUNTY OF CHARGE	MA115 (11/01/15)	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0602	MISSING OR INVALID DRG CODE	N208 (11/01/15)	Missing/incomplete/invalid DRG code.
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0604	INVALID PRICING ACTION CODE	MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (02/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0607	LOW VARIANCE ERROR	M79 (02/01/16)	Missing/incomplete/invalid charge.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0609	DRG DIRECT COST, LOW TRIM OR HIGH TRIM PER DIEM EQUAL ZERO	N208 (11/01/15)	Missing/incomplete/invalid DRG code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0612	PER DIEM INPATIENT RATE NOT FOUND ON PROVIDER RATE FILE	N147 (01/01/14)	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0618	VALID RATE FOR DATES OF SERVICE NOT FOUND ON RATE FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0621	DRG CODE NOT ON FILE	N208 (01/01/14)	Missing/incomplete/invalid DRG code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0624	NO VALID PRICE FOR DATE OF SERVICE ON USUAL & CUSTOMARY FILE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0639	REFERRING PROVIDER MUST BE NURSING FACILITY	N276 (11/01/15)	Missing/incomplete/invalid other payer referring provider identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0642	RESUBMIT CLM WITH INVOICE OR MANUFACTURER'S PRICE LIST	N63 (11/01/15)	Rebill services on separate claim lines.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0643	OUT OF REGION NON-DRG HOSPITAL REQ MAN PRICING FOR DOS	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0644	OUT OF REG NON-DRG HOSP REQ MAN PRICING-NO PROV RATE RECORD	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0646	MISSING NEW YORK REGIONAL BAD DEBT MULTIPLIER	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0647	MISSING PENNSYLVANIA DRG EXEMPT PER DIEM RATE	N213 (11/01/15)	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0648	INVALID NEW YORK EXEMPT UNIT RATE CODE	N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0649	MISSING NEW YORK EXEMPT UNIT RATE DATA	N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.
16 (05/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0657	MISSING NJ DRG PAYOR FACTOR	N208 (05/01/16)	Missing/incomplete/invalid DRG code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0658	NO PROVIDER RATE RECORD FOR BILLING PROVIDER	N182 (11/01/15)	This claim/service must be billed according to the schedule for this plan.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0659	NF RATE NOT ON FILE	N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0660	NUMBER OF ACCOMMODATION DAYS NOT EQUAL TO TOTAL BILLED DAYS	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0661	INV/MISS DRG CODE	N208 (11/01/15)	Missing/incomplete/invalid DRG code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0663	USE PROPER PROCEDURE CODE-SEE NEWSLETTER P669 DATED 08/91	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0668	USE ASSIGNED PROC CODE/NDC CODE TO MATCH DESCRIPTION GIVEN	M51 (10/16/03)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0671	MEDICARE RATE NOT ON FILE	N471 (11/01/15)	Missing/incomplete/invalid HIPPS Rate Code.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0704	OUTPATIENT ACUTE-ADULT PARTIAL HOSPITALIZATION - PA REQUIRED	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0708	GLOBAL OB CARE/SERVICE CONFLICT	M67 (10/16/03)	Missing/incomplete/invalid other procedure code(s).



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0726	INDIVID LAB TESTS EXCEEDS PANEL ALLOWANCE -REDUCED PAYMENT.	MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0727	INDIVIDUAL LAB TESTS ALLOWANCE EXCEEDS PANEL ALLOWANCE	MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0728	INDIVIDUAL LAB TEST/CBC CONFLICT	MA110 (11/01/15)	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0770	PROCEDURE CODE/NDC NOT INCLUDED IN PRIOR AUTHORIZATION	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0771	DAY SUPPLY INCORRECTLY REPORTED AS ONE DAY.	M53 (10/16/03)	Missing/incomplete/invalid days or units of service.
16 (07/23/04)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0778	NO IMMUNIZATION CODE PROVIDED ON THE SAME DAY OF SERVICE	N20 (11/01/15)	Service not payable with other service rendered on the same date.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0786	PREVIOUSLY DENIED CLAIM CANNOT BE ADJUSTED-RESUBMIT CLAIM	N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0789	FORMER ICN INVALID (FFS)	M122 (01/01/16)	Missing/incomplete/invalid level of subluxation.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0796	BILLING PROVIDER NOT MATCHED ON HISTORY	N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0799	NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST	N5 (08/31/04)	EOB received from previous payer. Claim not on file.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0841	PROVIDER CANNOT BE SURGEON & ASST SURGEON/ANESTHESIOLOGIST	N250 (01/01/14)	Missing/incomplete/invalid assistant surgeon secondary identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0943	REBILL CLAIM WITH MEDICARE PAID LINES ONLY	N4 (11/01/15)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0944	PROCEDURE CODE AND/OR CHARGES ON CLAIM DO NOT MATCH EOB	N34 (11/01/15)	Incorrect claim form/format for this service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0946	RA SHOWING MEDICAID CROSSOVER PAYMENT MUST BE ATTACHED	MA92 (01/01/14)	Missing plan information for other insurance.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0947	MEDICARE OUTPATIENT PART B EOB MISSING	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
16 (01/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0955	CLAIM VOIDED - RESUBMITTED AS ORIGINAL CLAIM	N142 (01/01/16)	The original claim was denied. Resubmit a new claim, not a replacement claim.



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0972	NO EOB ATTACHED-RECIPIENT WITH OTHER RESOURCE INDICATED	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0981	BENEFICIARY/DATES OF SERVICE DO NOT MATCH EOB/LETTER	M59 (01/29/16)	Missing/incomplete/invalid 'to' date(s) of service.
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0982	EOB INDICATES BILLING ERROR, REVIEW OR REBILL TO CARRIER	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0983	RESOURCE FILE INDICATES INSURANCE OTHER THAN PAYOR ID CODED	M56 (01/01/14)	Missing/incomplete/invalid payer identifier.



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0984	CLAIM REQUIRES REVIEW - MEDICARE PART B ATTACHMENT	N480 (01/29/16)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0985	ENTER TPL AMT PAID FROM EOB IN PRIOR PMT BOX ON CLAIM FORM	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0986	INVALID PAYOR ID	M56 (10/16/03)	Missing/incomplete/invalid payer identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0988	NEGATIVE MEDICARE EOB, REBILL AS ZERO PRIOR PAY	N480 (11/01/15)	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).



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16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0989	INVALID APPROPRIATION CODE ASSIGNMENT	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (10/16/03)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0994	NO MATCHING PA MASTER FOR AJ CREDIT	M49 (11/01/15)	Missing/incomplete/invalid value code(s) or amount(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0998	INCORRECT PAAD CLAIM	N34 (11/01/15)	Incorrect claim form/format for this service.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0999	PROCESSING ERROR/CLAIM WAS RESUBMITTED BY FISCAL AGENT	N142 (11/01/15)	The original claim was denied. Resubmit a new claim, not a replacement claim.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1001	REVENUE UNITS (OCCURS 45 TIMES) ARE GREATER THAN 999	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1002	DAYS ACUTE ARE GREATER THAN 999	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1003	DAYS SNF ARE GREATER THAN 999	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1004	DAYS ICF ARE GREATER THAN 999	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1005	DAYS RESIDENTIAL ARE > 999	M53 (11/01/15)	Missing/incomplete/invalid days or units of service.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1010	INVALID LTC PATIENT/OTHER PAYMENT AMOUNT	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1022	CAPITATION PAYMENT REDUCED BY MAX PATIENT PAYMENT LIABILITY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1025	CAP PAYMENT PART REDUCED BY MAX PATIENT LIABILITY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1200	OCC SPAN DAY DOES NOT MATCH THE NUMBER OF REVENUE UNITS	M46 (01/01/14)	Missing/incomplete/invalid occurrence span code(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1209	DOS SPANS PROVIDER FISCAL YR, MULTIPLE RATE USED FOR PRICING	N62 (11/01/15)	Dates of service span multiple rate periods. Resubmit separate claims.
16 (06/04/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1214	INVALID NDC OR NDC NOT ON FILE	M119 (06/04/07)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (06/04/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1215	PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE	M20 (06/04/07)	Missing/incomplete/invalid HCPCS.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1217	TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER	N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1218	TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER	N255 (05/23/07)	Missing/incomplete/invalid billing provider taxonomy.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1219	TAXONOMY CODE IS MISSING FOR SERVICING PROVIDER	N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1220	TAXONOMY CODE IS INVALID FOR SERVICE PROVIDER	N288 (05/23/07)	Missing/incomplete/invalid rendering provider taxonomy.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1221	NPI IS MISSING FOR SERVICE/RENDERING PROVIDER	N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1222	NPI IS INVALID FOR SERVICE/RENDERING PROVIDER	N290 (05/23/07)	Missing/incomplete/invalid rendering provider primary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1223	NPI IS MISSING FOR ATTENDING PROVIDER	N252 (01/15/13)	Missing/incomplete/invalid attending provider name.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1224	NPI IS INVALID FOR ATTENDING PROVIDER	N252 (01/15/13)	Missing/incomplete/invalid attending provider name.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1226	NPI IS INVALID FOR REFERRING PROVIDER	N286 (05/23/07)	Missing/incomplete/invalid referring provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1227	NPI IS MISSING FOR OPERATING PROVIDER	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1228	NPI INVALID - UB04 OPERATING 1 PROVIDER	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1229	NPI IS MISSING FOR BILLING PROVIDER	N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1230	NPI IS INVALID FOR BILLING PROVIDER	N257 (01/15/13)	Missing/incomplete/invalid billing provider/supplier primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1231	NPI IS MISSING FOR OTHER PROVIDER	N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1232	NPI IS INVALID FOR OTHER PROVIDER	N270 (05/23/07)	Missing/incomplete/invalid other provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1233	NPI MISSING FOR PRESCRIBING PROVIDER	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1234	NPI INVALID FOR PRESCRIBING PROVIDER	N265 (01/15/13)	Missing/incomplete/invalid ordering provider primary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1235	NPI NOT ON FILE FOR SERVICE/RENDERING PROVIDER	M49 (05/23/07)	Missing/incomplete/invalid value code(s) or amount(s).
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1236	ZIP CODE IS MISSING OR INVALID	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1237	NPI NOT CROSSWALKED - SERV/REND	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1238	PROVIDER NOT MATCHED - SERV/REND	N291 (05/23/07)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1240	NPI NOT CROSSWALKED - BILLING	N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1241	PROVIDER NOT MATCHED - BILLING	N259 (05/23/07)	Missing/incomplete/invalid billing provider/supplier secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1242	PROVIDER ID AND NPI REQUIRED - BILLING	N259 (01/01/13)	Missing/incomplete/invalid billing provider/supplier secondary identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1243	NPI NOT CROSSWALKED - ATTENDING	N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1244	PROVIDER NOT MATCHED - ATTENDING	N254 (05/23/07)	Missing/incomplete/invalid attending provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1245	PROVIDER ID AND NPI REQUIRED - SERVICING	N291 (01/01/13)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1246	NPI NOT CROSSWALKED - UB04 REFERRING PROVIDER	N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1247	PROVIDER NOT MATCHED - REFERRING	N287 (05/23/07)	Missing/incomplete/invalid referring provider secondary identifier.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1252	MISSING DEDUCTIBLE, COINSURANCE OR CO-PAYMENT AMOUNT	MA34 (11/01/15)	Missing/incomplete/invalid number of coinsurance days during the billing period.
16 (02/01/19)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1258	SERVICES PAID AT CHILDREN'S RATE	N45 (01/01/08)	Payment based on authorized amount.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1260	PROVIDER ID AND NPI REQUIRED - ATTENDING	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1261	NPI NOT CROSSWALKED - OPERATING	N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1262	PROVIDER NOT MATCHED - UB04 OPERATING 1 PROVIDER	N263 (05/23/07)	Missing/incomplete/invalid operating provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1263	PROVIDER ID AND NPI REQUIRED - REFERRING	N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1264	NPI NOT CROSSWALKED - OTHER	N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.



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16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1265	PROVIDER NOT MATCHED - OTHER	N271 (05/23/07)	Missing/incomplete/invalid other provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1266	PROVIDER ID AND NPI REQUIRED - OPERATING 1	N263 (01/01/13)	Missing/incomplete/invalid operating provider secondary identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1267	NPI NOT CROSSWALKED - PRESCRIBING	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.
16 (05/23/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1268	PROVIDER NOT MATCHED- PRESCRIBING	N31 (05/23/07)	Missing/incomplete/invalid prescribing provider identifier.



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16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1269	ATTENDING NPI SAME AS BILLING/SERVICING NPI	N253 (07/01/08)	Missing/incomplete/invalid attending provider primary identifier.
16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1270	REFERRING NPI SAME AS BILLING/SERVICING NPI	N286 (07/01/08)	Missing/incomplete/invalid referring provider primary identifier.
16 (07/01/08)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1271	OTHER NPI SAME AS BILLING/SERVICING NPI	N270 (07/01/08)	Missing/incomplete/invalid other provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1280	NPI INVALID - UB04 OPERATING 2 PROVIDER	N262 (09/07/10)	Missing/incomplete/invalid operating provider primary identifier.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1281	UB04 OPERATING 1 NPI SAME AS BILLING/SERVICING NPI.	N262 (01/15/13)	Missing/incomplete/invalid operating provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1282	NPI NOT CROSSWALKED-UB04 OPERATING 2 PROVIDER	N263 (09/07/10)	Missing/incomplete/invalid operating provider secondary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1284	INVALID/MISSING UB04 OCCURRENCE SPAN CODE	M46 (11/01/15)	Missing/incomplete/invalid occurrence span code(s).
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1285	INVALID UB04 OCCURRENCE SPAN FROM DATE	N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1286	INVALID UB04 OCCURRENCE SPAN THRU DATE	N46 (09/07/10)	Missing/incomplete/invalid admission hour.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1287	STATEMENT THRU DATE < UB04 OCCUR SPAN THRU DATE	N300 (11/01/15)	Missing/incomplete/invalid occurrence span date(s).
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1290	UB04 PAT RSN VISIT REQD - UNSCHEDULED VISIT	M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1295	UB04 OPERATING 2 NPI. SAME AS BILLING/SERVICE NPI.	N253 (09/07/10)	Missing/incomplete/invalid attending provider primary identifier.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1296	PROVIDER ID AND NPI REQUIRED - OPERATING 2	N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1297	BILLING ZIP CODE IS MISSING OR INVALID	N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1298	TAXONOMY CODE IS INVALID FOR ATTENDING PROVIDER	N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1299	TAXONOMY CODE IS INVALID FOR REFERRING PROVIDER	N255 (05/09/11)	Missing/incomplete/invalid billing provider taxonomy.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1305	INVALID SUPERVISING MEDICAID PROVIDER ID.	N297 (11/01/15)	Missing/incomplete/invalid supervising provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1306	NPI IS INVALID FOR SUPERVISING PROVIDER	N290 (05/09/11)	Missing/incomplete/invalid rendering provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1307	NPI NOT CROSSWALKED - SUPERVISING PROVIDER	N291 (05/09/11)	Missing/incomplete/invalid rendering provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1309	SUPERVISING PROVIDER NOT ON FILE	N31 (05/09/11)	Missing/incomplete/invalid prescribing provider identifier.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1310	MISSING/INVALID DENTAL CLINIC REV CODE.	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1311	MISSING/INVALID DENTAL PROCEDURE CODE.	M51 (11/01/15)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1312	MISSING OR INVALID PRESENT ON ADMISSION INDICATOR.	N434 (12/09/13)	Missing/Incomplete/Invalid Present on Admission indicator.
16 (06/08/09)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1317	INVALID/MISSING METRIC QUANTITY	M123 (06/08/09)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1320	POA INDICATOR HAS NO CORRESPONDING DIAGNOSIS CODE.	N434 (11/01/15)	Missing/Incomplete/Invalid Present on Admission indicator.
16 (06/08/09)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1321	CLAIM UOM INVALID OR NOT = NDC UOM - SEE WWW.NJMMIS.COM	M49 (06/08/09)	Missing/incomplete/invalid value code(s) or amount(s).
16 (04/02/10)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1324	EFFECT 1/1/2012 PYMT WILL BE DEFERRED PENDING ACH ENROLLMENT	M56 (11/01/15)	Missing/incomplete/invalid payer identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1330	METRIC QUANTITY INCORRECTLY REPORTED FOR DRUG BILLED	N378 (11/01/15)	Missing/incomplete/invalid prescription quantity.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1332	UNSUBMITTED TAXONOMY CODE WAS DEFAULTED	N255 (11/01/15)	Missing/incomplete/invalid billing provider taxonomy.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1339	RECIPIENT ENROLLMENT IN MULTIPLE MANAGED CARE PLANS	N216 (01/01/12)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1342	TENT PAY PRICE USING PHY FEE INCREASE-AFFORDABLE CARE ACT	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1343	ADV PRACTICE NURSE INELIGIBLE TO RECEIVE ACA ENHANCED PAYMNT	MA112 (01/01/16)	Missing/incomplete/invalid group practice information.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1344	BIRTH WEIGHT ON CLAIM AND DRG CONFLICT	N207 (09/09/13)	Missing/incomplete/invalid weight.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1345	RESUBMIT CLAIM WITH ELIGIBLE MEDICAID RECIPIENT ID	MA27 (12/01/14)	Missing/incomplete/invalid entitlement number or name shown on the claim.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1352	DME AUDIT - NO DOCUMENTATION - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1353	DME AUDIT - INCORRECT RECIP IDENT - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1354	DME AUDIT - NO PROOF OF PURCHASE - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1355	DME AUDIT - NO PROOF OF DELIVERY - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1356	DME AUDIT - NO PRESCRIBER ORDER - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1357	DME AUDIT - DIFFERENT PROC/PRODUCT - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1358	DME AUDIT - DIFFERENT QTY BILLED/AUTH - (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1359	DME AUDIT - DIFFERENT PROC BILLED/AUTH - CALL (800-310-0865)	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1360	DME AUDIT - NO PRICE LIST - CALL (800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1361	DME AUDIT- INVALID DATE OF SERVICE - CALL(800) 310-0865	M58 (01/01/11)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1362	LTC XOVER MISSING MCARE PAID &/OR MCARE COV DAYS &/OR COINS	M79 (11/01/15)	Missing/incomplete/invalid charge.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1365	HMS PERMEDION NJUR	M129 (10/01/20)	Missing/incomplete/invalid indicator of x-ray availability for review.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1366	HMS RECOVERY - PATIENT DECEASED ON DOS	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1375	HMS CREDIT BALANCE RECOVERY - ON-SITE FINANCIAL REVIEW	M129 (11/01/15)	Missing/incomplete/invalid indicator of x-ray availability for review.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1379	PMT AMT ON THE APPROVED HMS ADJ GT THAN OR EQUAL TO ORIG PMT	N307 (11/01/15)	Missing/incomplete/invalid adjudication or payment date.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1387	PROVIDER ID AND NPI REQUIRED - PRESCRIBING	N31 (01/01/13)	Missing/incomplete/invalid prescribing provider identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1389	ATTENDING PROVIDER INELIGIBLE ON DATES OF SERVICE	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1392	OPERATING 1 PROVIDER INELIGIBLE ON DATES OF SERVICE	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1393	OPERATING 2 PROVIDER INELIGIBLE ON DATES OF SERVICE	N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1394	SUPERVISING PROVIDER INELIGIBLE ON DATES OF SERVICE	N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1395	ATTENDING PROVIDER NOT FOUND ON PROVIDER DATABASE	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1396	PRESCRIBING PROVIDER NOT FOUND ON PROVIDER DATABASE	N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1397	REFERRING PROVIDER NOT FOUND ON PROVIDER DATABASE	N287 (01/01/13)	Missing/incomplete/invalid referring provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1398	OPERATING 1 PROVIDER NOT FOUND ON PROVIDER DATABASE	N263 (01/15/13)	Missing/incomplete/invalid operating provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1399	OPERATING 2 PROVIDER NOT FOUND ON PROVIDER DATABASE	N250 (01/01/13)	Missing/incomplete/invalid assistant surgeon secondary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1400	NO OCCURRENCE SPAN CODE 74 OR 77	M46 (12/09/13)	Missing/incomplete/invalid occurrence span code(s).



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1402	SUPERVISING PROVIDER NOT FOUND ON PROVIDER DATABASE	N298 (01/15/13)	Missing/incomplete/invalid supervising provider secondary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1403	NPI NOT CROSSWALKED-ATTENDING	N254 (01/01/13)	Missing/incomplete/invalid attending provider secondary identifier.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1404	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - BILLING	N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1405	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SERVICING	N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1406	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - ATTENDING	N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1410	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - REFERRING	N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1411	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 1	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1412	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - OPERATING 2	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1413	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - PRESCRIBING	N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1414	NPI NOT REGISTERED WITH NEW JERSEY MEDICAID - SUPERVISING	N297 (07/14/14)	Missing/incomplete/invalid supervising provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1415	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - BILLING	N257 (07/14/14)	Missing/incomplete/invalid billing provider/supplier primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1416	ICD VERSION MISMATCH	M64 (10/01/14)	Missing/incomplete/invalid other diagnosis.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1418	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SERVICING	N290 (07/14/14)	Missing/incomplete/invalid rendering provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1419	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - ATTENDING	N253 (07/14/14)	Missing/incomplete/invalid attending provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1420	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - REFERRING	N286 (07/14/14)	Missing/incomplete/invalid referring provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1421	NPI NOT MAPPED WITH NEW JERSEY PROVIDER ID - OPERATING 1	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1422	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - OPERATING 2	N262 (07/14/14)	Missing/incomplete/invalid operating provider primary identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1423	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - PRESCRIBING	N31 (07/14/14)	Missing/incomplete/invalid prescribing provider identifier.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1425	INVALID DIAGNOSIS FOR SERVICE	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1427	NPI NOT MAPPED TO THIS NEW JERSEY PROVIDER ID - SUPERVISING	N291 (07/14/14)	Missing/incomplete/invalid rendering provider secondary identifier.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1428	UNSPECIFIED DIAGNOSIS CODE	M81 (10/01/14)	You are required to code to the highest level of specificity.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1430	OUTPATIENT TRANSPORTATION SERVICE HAS NO RATE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1431	OUTPATIENT SERVICE NOT PAYABLE TRANS/PERS	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1438	HOSPICE SERVICE INTENSITY ADD-ON LIMIT EXCEEDED	N56 (01/01/16)	Procedure code billed is not correct/valid for the services billed or the date of service billed.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1439	ROUTINE HOME CARE HOSPICE WITH MOD 22 PRICED AT LOWER RATE	N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1440	PROCEDURE NEEDS A DATE OF DEATH TO BE PROCESSED	N330 (01/01/16)	Missing/incomplete/invalid patient death date.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1441	RECIP OUTSIDE 60 DAYS NOT ELIGIBLE FOR HIGHER HOSPICE RATE	N657 (01/01/16)	This should be billed with the appropriate code for these services.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1442	CLAIMS REPROCESS FOR DSNP MEMBERS	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1443	HOSPICE DOS OVERLAP THE FIRST 60 DAYS OF HOSPICE CARE	N62 (01/01/16)	Dates of service span multiple rate periods. Resubmit separate claims.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1444	SERVICE INTENSITY ADD-ON PROCEDURE BEYOND 7 DAYS	N182 (01/01/16)	This claim/service must be billed according to the schedule for this plan.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1449	ICD10 SURG PROC CD MAINTENANCE. REPROCESS ON APPROVAL.	M51 (10/03/16)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1450	ICD10 DIAG CD MAINTENANCE. REPROCESS ON APPROVAL.	M51 (10/31/16)	Missing/incomplete/invalid procedure code(s).



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1451	UNKNOWN FIELD POPULATED WITH INVALID DATA	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1456	PENDING IME ROOM & BOARD CHANGES FOR SUD. REPROCESS ON APPVL	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1457	PEND ALL CLAIMS FOR PROCEDURE CODE 97127HI	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1460	CMS PROC CODE MAINTENANCE. REPROCESS ON APPROVAL	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1461	INCORRECT SUBMITTER ID FOR EVV SERVICE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1462	INCORRECT SUBMITTER ID FOR EVV SERVICE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1476	L&D ANESHESIA > 40 UNITS BILLED WAS REDUCED	N203 (03/19/25)	Missing/incomplete/invalid anesthesia time/units.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1602	OP PSYCH SERVICE IN CONFLICT WITH Y99XX CLAIM	M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1616	FQHC HCPCS WITH NO ENCOUNTER FOUND	M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1633	PA REQUIRED FOR PARTIAL CARE	MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1634	NON-EMERGENCY TRANSPORTATION PROCEDURE	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1635	ORIGINAL APPRP CODE NOT IN USE, FIELD UPDATED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1636	MEDICARE CROSSOVER CLAIM PAID AND DUPLICATE DME CLAIM VOIDED	N8 (11/01/15)	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1640	HOSPICE TRANSFER DAY OF DISCHARGE PAYMENT CUTBACK	MA31 (01/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1643	CLAIM VOID PENDED - UNCONFIRMED RECIPIENT DEATH	N330 (11/01/15)	Missing/incomplete/invalid patient death date.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1644	CLAIM VOIDED - RECIPIENT DEATH	N330 (11/01/15)	Missing/incomplete/invalid patient death date.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1645	HMS MEDICARE COVERAGE IS NOT PRESENT ON TPL	MA64 (11/01/15)	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1650	MISSING QUALIFYING OTHER PROCEDURE ON DAY OF SERVICE	N302 (11/01/15)	Missing/incomplete/invalid other procedure date(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1653	PAYMT BASED ON AFFORDABLE CARE ACT ENHANCED RATES CY 13 & 14	M67 (01/01/14)	Missing/incomplete/invalid other procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1654	RECIPIENT INELIGIBLE FOR ACA TITLE 19	MA43 (01/01/14)	Missing/incomplete/invalid patient status.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1660	NO APPROPRIATE E&M, MH OR SUD CODE IN HISTORY	N657 (11/01/15)	This should be billed with the appropriate code for these services.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1663	CLAIM VOIDED - PARIS MATCH	N424 (08/01/24)	Patient does not reside in the geographic area required for this type of payment.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1669	NO RECORD OF AN EPISODE OF CARE ON FILE	N173 (11/01/15)	No qualifying hospital stay dates were provided for this episode of care.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1671	SERVICE DATE/HCPDS COMBINATION MATCH OCCURRENCE IN HISTORY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1674	REPROCESS PE CLAIMS NOW ELIGIBLE FOR NEW ADULT GROUP	MA67 (06/08/15)	Alert: Correction to a prior claim.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1712	DIABETES SERVICES CLM HAS NO REQ'D PREV CLMS ON HISTORY	M53 (11/22/22)	Missing/incomplete/invalid days or units of service.
16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1808	CLAIM CHECK: INVALID PROCEDURE CODE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1809	CLAIM CHECK: DOB CANNOT BE GREATER THAN DATE OF SERVICE	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1811	CLAIM CHECK: PROCEDURE CODE IS OBSOLETE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1819	CLAIM CHECK: SERVICE DAYS EXCEED NUMBER OF UNITS	N345 (06/18/07)	Date range not valid with units submitted.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1820	CLAIM CHECK: DATE OF SERVICE IS A FUTURE DATE	M52 (06/18/07)	Missing/incomplete/invalid 'from' date(s) of service.
16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1821	CLAIM CHECK: BIRTH DATE IS A FUTURE DATE	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1822	CLAIM CHECK: MISSING PROCEDURE CODE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1823	CLAIM CHECK: NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAYS	N345 (06/18/07)	Date range not valid with units submitted.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1829	CLAIM CHECK: PROCEDURE NOT INDICATED FOR A MALE	MA39 (11/01/15)	Missing/incomplete/invalid gender.
16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1830	CLAIM CHECK: NUMBER OF PROCEDURES IS GREATER THAN 100	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).



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16 (12/12/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1849	CLAIM CHECK: INVALID DATE OF BIRTH CENTURY VALUE	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1850	CLAIM CHECK: INVALID DATE OF BIRTH	N329 (01/01/14)	Missing/incomplete/invalid patient birth date.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1851	CLAIM CHECK: INVALID CLAIM DATE OF SERVICE	M52 (01/01/14)	Missing/incomplete/invalid 'from' date(s) of service.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1852	CLAIM CHECK: INVALID DATE OF SERVICE	M52 (01/01/14)	Missing/incomplete/invalid 'from' date(s) of service.



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16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1853	CLAIM CHECK: INVALID CHARGE AMOUNT	M54 (06/18/07)	Missing/incomplete/invalid total charges.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1854	CLAIM CHECK: INVALID NUMERIC FIELD	M79 (12/12/07)	Missing/incomplete/invalid charge.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1857	CLAIM CHECK: NUMERIC FIELD NOT POPULATED	M79 (12/12/07)	Missing/incomplete/invalid charge.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1862	CLAIM CHECK: MISSING PROVIDER ON CLAIM	N32 (06/18/07)	Claim must be submitted by the provider who rendered the service.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1877	CLAIM CHECK: PROCEDURE NOT EXPECTED FOR DIAGNOSIS	M51 (01/01/13)	Missing/incomplete/invalid procedure code(s).
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1882	CLAIM CHECK: ASSISTANT SURGEON DENIED	N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.
16 (11/01/15)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1883	CLAIM CHECK: ASSISTANT AT SURGERY DENIED	N247 (06/18/07)	Missing/incomplete/invalid assistant surgeon taxonomy.
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1885	CLAIM CHECK: CCI INCIDENTAL PROCEDURE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).



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16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1886	CLAIM CHECK: CCI MUTUALLY EXCLUSIVE PROCEDURE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1887	CLAIM CHECK: INCIDENTAL PROCEDURE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1889	CLAIM CHECK: MUTUALLY EXCLUSIVE PROCEDURE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1896	CLAIM CHECK: MEDICAL VISIT PROCEDURE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).



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16 (06/18/07)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1897	CLAIM CHECK: DIAGNOSIS NOT EXPECTED FOR PROCEDURE	M51 (06/18/07)	Missing/incomplete/invalid procedure code(s).
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2007	PA INDICATOR ON THE DRUG FILE IS = 'A' OR 'Y'		
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2010	WRONG PCN (104-A4) - VALUE MUST = SUPPNJ, ADDP, OR PAAD	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2038	FIRST FILL OF THIS DRUG (BY NDC/GCN/STC) REQUIRES PRIOR AUTH		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2048	PHARMACY NOT APPROVED STATE PROVIDER		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2050	LICENSE # ONLY ACCEPTED FOR NPI EXCLUDED ENTITIES.		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2051	FIELD 466-EZ MAY NOT CONTAIN 05 QUALIFIER - USE 01 FOR NPI		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2052	PART D CLAIM EMERGENCY SUPPLY - NO PDP REJECT CODE		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2053	PART D REJECT CODE CONFLICTS WITH PDP PAYMENT AMOUNT		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2054	CLAIM IS INCORRECTLY BILLED - NO MEDICARE ON FILE.		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2056	THE LENGTH OF THE SERVICE/BILLING NPI IS INVALID		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2057	SERVICE/BILLING PROVIDER NPI FAIL CHECK DIGIT 201-B1		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2058	SERVICING/BILLING PROVIDER NPI IS REQUIRED OF 05/23/08		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2059	THE FIRST DIGIT OF THE SERVICING/BILLING NPI IS INVALID		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2060	THE MEDICAID ID IS NOT FOUND FOR SERVICING/BILLING NPI		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2061	FOUND MULTIPLE MEDICAID IDS FOR THE SERVICING/BILLING NPI		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2062	THE LENGTH OF THE PRESCRIBER NPI IS INVALID - 411-DB		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2063	CHECK DIGIT VALIDATION FAIL FOR THE PRESCRIBER NPI		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2064	PRESCRIBER NPI IS REQUIRED AS OF 05/23/08		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2065	THE FIRST DIGIT OF PRESCRIBER NPI IS INVALID		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2069	METRIC QUANTITY MUST REFLECT WHOLE PACKAGE		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2070	EXCEEDS MAXIMUM METRIC QUANTITY FOR PACKAGE SIZE/ FULL PKGS		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2071	PAAD RECIPIENTW/ MEDICAID ELIGIBILITY		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2072	DUPLICATE STATE LICENSE # FOUND ON PROVIDER FILE		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2076	SENIOR GOLD RECIPIENT W/MEDICAID ELIGIBILITY		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2083	DAYS SUPPLY > 34 FOR NURSING HOME EARLY REFILL		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2084	PRESCRIPTION FILLED BY MAILORDER PHARMACY		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2085	MAC OVERRIDE NOT ALLOWED - DISPENSE AS WRITTEN IND INCORRECT		



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2086	SUBMISSION OF 6666666 FOR NJ PRESCRIBER IS INVALID		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2090	PRESCRIBER LIC#/QUALIFIER N/A WHEN NPI EXISTS		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2097	PHARMACY BILLED FOR TPL COPAY/COINSURANCE		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2098	INVALID COMPOUND - CONTAINS ONE INGREDIENT PLUS WATER		



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2099	INCORRECT UNIT OF MEASURE REPORTED FOR DRUG		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2100	FDB DAILY DOSAGE QUANTITY STANDARD EXCEEDED		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2102	DUPLICATE PHARMACY/SERVICE DATE/PRESCRIPTION NUMBER		
16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2120	LAST CHARACTER OF SIGNED FIELD IS NUMERIC & MUST BE SIGNED		



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16 (04/01/18)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2144	ADDP PARTD-SUBMIT 10-DIGIT ADDP ID NUMBER NOT HBID NUMBER		
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2147	5.1 VERSION NOT ALLOWED FOR SUBMITTER APPROVED FOR D.O	N251 (09/01/20)	Missing/incomplete/invalid attending provider taxonomy.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2148	PA NUMBER INPUT REQUIRES SPECIAL FORMAT FOR HMS TPL CLAIMS	M62 (09/01/20)	Missing/incomplete/invalid treatment authorization code.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2150	HMS AUDITORS NOT ALLOWED IN PHARMACY	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2152	CLAIM DOES NOT BELONG TO PHARMACY	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2155	CLAIM WAS PREVIOUSLY RESERVED BY THE PHARMACY	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2158	DS AND QTY CHANGED TO BE CONSISTENT WITH DOCTOR'S DIRECTIONS	M53 (09/01/20)	Missing/incomplete/invalid days or units of service.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2159	RX INCOMPLETE-MISSING/INCOMP/AMBIG PRESRBRS AUTH AGENT	N668 (09/01/20)	Incomplete/invalid prescription.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2160	WRONG DAYS SUPPLY; CHNGED TO BE CONSISTENT W/ DR'S DIRCTNS	M53 (09/01/20)	Missing/incomplete/invalid days or units of service.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2161	ERRONEOUS CLAIM	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2163	MISSING INGREDIENTS	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2164	DRUG BILLED IS DIFFERENT THAN PRESCRIBED/DISPENSED	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2165	INCORRECT QUANTITY BILLED FOR SINGLE PACKAGE ITEM	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2167	RESPONSE RECEIVED AFTER ALLOTTED TIMEFRAME	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2168	MISSING FAX HEADER	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2169	RX IS NOT ON FILE OR INCOMPLETE	N388 (09/01/20)	Missing/incomplete/invalid prescription number.



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16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2170	ACQUISITION INVOICE DOES NOT SUPPORT NDC BILLED	N657 (09/01/20)	This should be billed with the appropriate code for these services.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2171	PHARMACY FAILED TO RESPOND WITHIN ALLOTTED TIMEFRAME	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2172	INCORRECT OR INVALID DAW/DNS SUBMITTED	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2180	EXCESSIVE QUANTITY BILLED FOR DAYS SUPPLY SUBMITTED		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2181	QTY EXCEEDS DS LIMITS & INCORRECT PACKAGE SIZE BILLED/DISP		
16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2183	EXCEEDED REFILLS ALLOWED	N657 (09/01/20)	This should be billed with the appropriate code for these services.
16 (03/07/05)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2191	COPY OF RX WAS NOT PROVIDED	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2196	RX NOT TAMPER RESISTANT		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2201	INCORRECT/INVALID DATE RANGE ON INVOICE FOR NDC ON CLAIM		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2202	DE DEA# ON CONTROLLED RX (CII THRU CV) MISSING OR INVALID		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2203	EQ MAXIMUM DAILY QTY EXCEED		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2204	RH STRENGTH ON PRESCRIPTION MISSING		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2211	INSUFFICIENT INVOICE QUANTITY		
16 (02/01/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2213	INSUFFICIENT QTY-INVOICE DOC DOES NOT SUPPORT QTY BILLED		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2214	CLAIMS WAS PREVIOUSLY RESERVED BY THE PHARMACY		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2215	PHARMACY FAILED TO RESPOND WITHIN ALLOTTED TIMEFRAME		



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16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2216	CLAIM RESERVED AND MEDICATION WAS RETURNED TO STOCK		
16 (01/29/16)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2238	OTHER PAYER-PATIENT RESP AMT DOES NOT HAVE A CORRESP QUAL		
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2279	CLAIM SERVICE DATE OCCURS DURING DISASTER SITUATION	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2286	FACILITY ID NPI IS NOT NUMERIC OR CHECK DIGIT IS INVALID	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2287	FACILITY ID NPI NOT VALID ON NPPES PROVIDER DATABASE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2288	FACILITY NPI CANNOT BE MAPPED TO A MEDICAID ID	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2289	FACILITY ID NPI MAPS TO A NON-LTC MEDICAID PROVIDER	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2298	SUBMITTED PRESCRIBER NPI MAPS TO A GROUP ENTITY	N31 (01/01/19)	Missing/incomplete/invalid prescribing provider identifier.



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16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2325	OPIOID DRUG NOT FOUND ON MME FACTOR TABLE	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2327	450-EF COMPOUND DOSAGE FORM DESCRIPTION CODE IS INVALID	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (09/01/20)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2329	OPIOID NOT FOUND ON RGCNSTR0 TABLE	M119 (09/01/20)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2354	PAAD RECIPIENT W/ ADDP ELIGIBILITY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2355	SENIOR GOLD RECIPIENT W/ADDP ELIGIBILITY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2356	MAX NUMBER OF CLAIMS LIMITED TO 2 PER 12 MONTHS	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2357	SUBMITTED PRESCRIBER NPI DOESN'T MATCH STANDING ORDER NPI	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
16 (01/01/14)	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2360	OTC PREGNANCY TEST LIMIT - 1 PKG/CLAIM, 4 CLAIMS/30 DAYS	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0405	POSSIBLE THERAPEUTIC CLASS DUPLICATION		



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18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0695	ADJUSTMENT / VOID ALREADY IN PROCESS	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0795	CLAIM ADJUSTED BY SYSTEM - NEW ICN	N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0797	DUPLICATE ADJUSTMENT RECORDS ENTERED	M58 (10/16/03)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0800	EXACT DUPLICATE BILL	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0801	POSSIBLE DUPLICATE CONFLICT	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0802	PHYSICIAN AND EPSDT DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0803	INPATIENT AND LTC DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0804	INPATIENT AND OUTPATIENT DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0807	INPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0809	POSSIBLE DUPLICATE	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0810	DUPLICATE BILL - OVERLAPPING DATES OF SERVICES	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0812	TRANSPORTATION AND INPATIENT HOSPITAL DUPLICATE ERROR	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0813	OUTPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE ERROR	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0814	PHYSICIAN AND PHYSICIAN CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.



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18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0815	AMBULANCE AND AMBULANCE CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0816	CLINIC AND CLINIC CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0817	P&O AND P&O CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0818	DME AND DME CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0819	LAB AND LAB CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0820	OPTOMETRIST AND OPTOMETRIST CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0821	MID-LEVEL PRACT AND CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0822	EPSDT AND EPSDT CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0823	LTC AND LTC CROSSOVER DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0825	INPATIENT CLAIM CUTBACK BY PREVIOUSLY PAID OUTPATIENT CLAIM	N702 (01/29/16)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0827	PHARMACY EXACT DUPLICATE BILL - SAME PROVIDER	N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0828	PHARMACY EXACT DUPLICATE BILL - DIFFERENT PROVIDER		
18 (11/01/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0865	LTC AND HOSPICE DUPLICATE ERROR	N522 (11/01/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0899	DUPLICATE ICN	N702 (11/01/15)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.



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18 (10/16/03)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0951	POSSIBLE DUPLICATE CCF - SEE RA MESSAGE #300	N111 (01/01/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0954	CLAIM REPROCESSED TO CORRECT PAYMENTOR	N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
18 (01/29/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	0956	CLAIM REPROCESSED TO CORRECT PAYMENT	N111 (01/29/16)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1201	MULTIPLE HIST RECS FOUND FOR ADJ/VOID	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1607	FQHC DUPLICATE CONFLICT	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1622	CHARITY AND MEDICAID DUPLICATE ERROR	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1631	THERAPY CONFLICT WITH RESIDENTIAL, PARTIAL CARE, TRANSPORT	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1641	HOSPICE TRANSFER WITH MORE THAN ONE OVERLAPPING SERVICE DAY	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1642	HOSPICE XFER DAY OF DISCHARGE WITH > 1 OVERLAPPING SVC DAY	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (05/04/15)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1673	DEPT. OF CORRECTIONS/MEDICAID DUPLICATE ERROR	N522 (05/04/15)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (12/04/17)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1676	DAILY/WEEKLY PSYCHOTHERAPY SERVICE LIMITS EXCEEDED	N702 (12/04/17)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1812	CLAIM CHECK: PROCEDURE CODE IS MISSING	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/14)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1813	CLAIM CHECK: DATE OF SERVICE REQUIRED FOR PROCEDURE	N522 (01/01/14)	Duplicate of a claim processed, or to be processed, as a crossover claim.
18 (01/01/16)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	2118	THERAPEUTIC DUPLICATE FOUND USING NATIONAL STANDARD		



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18 (09/27/11)	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	2142	GENERIC DRUG HAS NO PRICE - SUL/FUL/WAC/NADAC MISSING	M86 (09/27/11)	Service denied because payment already made for same/similar procedure within set time frame.
22 (10/16/03)	This care may be covered by another payer per coordination of benefits.	0393	PAAD/SR GOLD PAYMENT BASED ON PENDING MEDICARE ENROLLMENT	N245 (11/01/15)	Incomplete/invalid plan information for other insurance.
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	0445	TPL NOT ON RESOURCE FILE BUT TPL AMT ON CLAIM		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	0459	CLAIM PYMT ADJUSTED DUE TO OTHER INSURANCE.		
22 (11/01/15)	This care may be covered by another payer per coordination of benefits.	0511	OVERRIDE-USE PROVIDER MEDICARE PER DIEM RATE.	N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
22 (01/01/14)	This care may be covered by another payer per coordination of benefits.	0637	MEDICARE COINSURANCE DAYS USED AS PAYABLE DAYS	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	0959	CLAIM UPDATED WITH TPL PAYMENT	N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	0973	CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCE	N4 (01/29/16)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
22 (01/15/24)	This care may be covered by another payer per coordination of benefits.	1473	TPL EDITING BYPASSED - PAY AND CHASE CLAIM	N883 (01/15/24)	Alert: Processed according to state law
22 (11/01/15)	This care may be covered by another payer per coordination of benefits.	1646	HMS PRIVATE COVERAGE IS NOT PRESENT ON THE TPL	MA64 (11/01/15)	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2011	PART D CLAIM PAID BY A DIFFERENT PDP THAN ON OUR FILE		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2017	PART D COVERAGE KNOWN BILL FOR PART D PLAN		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2041	TITLE XIX RECIPIENT-INVALID PART D DEDUCTIBLE AMOUNT		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2043	RECIPIENT ELIGIBLE FOR MEDICARE PART D		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2107	WRONG OTHER PAYER ID (340-7C) CORRECT CLIENT INFO & RESUBMIT		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2130	HMS TPL CLAIM W/NO COB AMOUNTS		



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22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2136	COB SEGMENT AND NO TPL PAID INFORMATION ON INPUT CLAIM		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2139	TPL PAYMENT AND REJECT CODE FOR OTHER PRIVATE PAYER		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2140	OTHER COVERAGE CODE=03 & CLAIM HAS NO SUPPORTING REJECT CODE		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2141	TPL PAYMENT AND OTHER COVERAGE CODE NOT EQUAL 02		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2145	PART B COVERAGE KNOWN - BILL PART B/PART D/TPL		
22 (01/01/16)	This care may be covered by another payer per coordination of benefits.	2146	COVERED BY ADDP HEALTH INSURANCE CONTINUATION (HIC) PROGRAM		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2224	INVALID OTHER PAYER AMOUNT PAID QUALIFIER FOR D.0 CLAIM		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2229	MISSING QUALIFIER FOR OTHER PAYER AMOUNT PAID		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2239	BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS.		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2240	OTHER PAYER ID FIELD MISSING OR INVALID		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2241	INVALID BENEFIT STAGE AMOUNT, NO PARTD PAYER SUBMITTED		
22 (01/29/16)	This care may be covered by another payer per coordination of benefits.	2250	TPL PAYER ID REQUIRED WHEN BILLING FOR TPL COPAY/COINSURANCE		
23 (01/01/14)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	0623	MEDICAID ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE	N669 (05/01/16)	Adjusted based on the Medicare fee schedule.
23 (10/16/03)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	0625	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	0882	ORTHODONTIC CUTBACK/INITIAL PAYMENT	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
23 (03/06/08)	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	0883	ORTHODONTIC CUTBACK/FINAL PAYMENT	M85 (10/16/03)	Subjected to review of physician evaluation and management services.



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24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	0300	HMO-COVERED SERVICE	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	0571	CAPITATION INDICATOR NOT MATCHED	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	0572	INVALID CAP CODE	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	0662	CLAIM PRICED-CHARGE TO MCAID AS PERCENT OF TOTAL CLM CHARGE	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	1021	CAPITATION PAYMENT REDUCED BY FULL PATIENT LIABILITY	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	1024	CAPITATION PAYMENT REDUCED BY PARTIAL PATIENT LIABILITY	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	1026	CAPITATION PAYMENT REDUCED FOR ELIGIBILITY LIMITS	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
24 (11/01/15)	Charges are covered under a capitation agreement/managed care plan.	1380	GHI CROSSOVER - SERVICE IS IN-PLAN (MANAGED CARE)	N59 (11/01/15)	Alert: Please refer to your provider manual for additional program and provider information.
26 (11/01/15)	Expenses incurred prior to coverage.	0110	DATE OF SERVICE < ADMISSION DATE	N652 (11/01/15)	The date of service is before the date of loss.
26 (11/01/15)	Expenses incurred prior to coverage.	0399	GA RECIPIENT ID CHANGED.	N30 (11/01/15)	Patient ineligible for this service.
26 (11/01/15)	Expenses incurred prior to coverage.	0521	RECIP NOT ON LTC MASTER FILE	N30 (11/01/15)	Patient ineligible for this service.
26 (11/01/15)	Expenses incurred prior to coverage.	0600	LTC RECIPIENT NOT ELIGIBLE ON DATE(S) OF SERVICE	N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.
26 (01/01/14)	Expenses incurred prior to coverage.	0613	DRG CODE SUBMITTED PRIOR TO DRG TRIM EFFECTIVE DATE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
26 (10/16/03)	Expenses incurred prior to coverage.	0634	DRG CODE SUBMITTED PRIOR TO PROVIDER'S DRG PAYMENT DATE	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
26 (10/16/03)	Expenses incurred prior to coverage.	0635	LTC NEW ADMIT DATE OF SERVICE PRIOR TO ASSESSMENT DATE	MA40 (10/16/03)	Missing/incomplete/invalid admission date.
27 (11/01/15)	Expenses incurred after coverage terminated.	0222	LTC AGREEMENT TERMINATED:DISCHARGE PENDING FINAL DAY	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.



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27 (11/01/15)	Expenses incurred after coverage terminated.	0525	LTC PASARR APPROVAL TERMINATED	N30 (11/01/15)	Patient ineligible for this service.
27 (11/01/15)	Expenses incurred after coverage terminated.	0528	LTC RECIP NOT ELIG FOR ENTIRE PERIOD-CUTBACK ASSESSMENT DTE	N30 (11/01/15)	Patient ineligible for this service.
27 (01/01/14)	Expenses incurred after coverage terminated.	0581	DENTAL SERVICES AFTER ELIGIBILITY TERMINATION	N30 (01/01/14)	Patient ineligible for this service.
31 (11/01/15)	Patient cannot be identified as our insured.	0368	NOT LOCK IN PHARMACY/EMERGENCY SUPPLY DISPENSED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
31 (10/16/03)	Patient cannot be identified as our insured.	0390	INVALID: REF PROV/ RCP CNTY/REF PROV TYP/PLC OF SVC FOR PROC	MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
31 (10/16/03)	Patient cannot be identified as our insured.	0394	MEDICARE ENROLLMENT REQUIRED TO RECEIVE PAAD/SR GOLD PAYMENT	MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
31 (11/01/15)	Patient cannot be identified as our insured.	0398	GA RECIPIENT ID CHANGED TO MEDICAID RECIPIENT ID.	MA61 (11/01/15)	Missing/incomplete/invalid social security number.
31 (10/16/03)	Patient cannot be identified as our insured.	0952	CLAIM VOIDED - RECIPIENT ID ERROR	MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
31 (01/01/16)	Patient cannot be identified as our insured.	2108	CARDHOLDER ID INVALID		
31 (01/29/16)	Patient cannot be identified as our insured.	2178	INCORRECT PATIENT INFORMATION SUBMITTED		
31 (01/29/16)	Patient cannot be identified as our insured.	2230	INVALID PATIENT RESIDENCE CODE. MUST BE 00-15		
31 (01/29/16)	Patient cannot be identified as our insured.	2278	CARDHOLDER ID ON PARTD VOID IS INVALID		
32 (01/01/16)	Our records indicate the patient is not an eligible dependent.	2023	BENEFICIARY INELIGIBLE FOR PART D ON DOS		
32 (01/01/16)	Our records indicate the patient is not an eligible dependent.	2036	RECIPIENT NOT ELIGIBLE FOR MAILORDER SERVICES		
35 (01/01/14)	Lifetime benefit maximum has been reached.	0601	PAYMENT REDUCED TO MEDICAID MAXIMUM	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.



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39 (01/01/16)	Services denied at the time authorization/pre-certification was requested.	2000	SERVICE ADMINISTRATIVELY DENIED		
40 (04/01/18)	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0605	OUT OF STATE DRG CLAIM REQUIRES MANUAL PRICING	N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
40 (11/01/15)	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0608	PEND FOR MANUAL PRICING	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
45 (03/25/15)	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	0630	LTC LEAVE DAYS CUT BACK TO MAXIMUM ALLOWED	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	1288	INVALID/MISSING UB04 ADMIT DIAGNOSIS	MA65 (11/01/15)	Missing/incomplete/invalid admitting diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	1289	UB04 ADMIT DIAGNOSIS NOT ON FILE	M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	1291	INVALID UB04 PATIENT REASON FOR VISIT	M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	1292	UB04 PATIENT REASON FOR VISIT NOT ON FILE	M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	1293	INVALID UB04 EXTERNAL INJURY CODE	M64 (11/01/15)	Missing/incomplete/invalid other diagnosis.
47 (09/07/10)	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	1294	UB04 EXTERNAL INJURY CODE NOT ON FILE	M64 (09/07/10)	Missing/incomplete/invalid other diagnosis.
49 (01/01/14)	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0752	VISIT OR SERVICE NOT PAYABLE WITH COMPREHENSIVE EYE EXAM	N429 (01/01/14)	Not covered when considered routine.



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49 (01/01/14)	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0753	SURGERY/VISIT CONFLICT	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
50 (11/01/15)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0524	INVALID LTC PSYCH RECIPIENT AGE	N129 (11/01/15)	Not eligible due to the patient's age.
50 (08/01/20)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1426	EARLY ELECTIVE DELIVERY	N661 (08/02/20)	Documentation does not support that the services rendered were medically necessary.
50 (01/01/21)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1469	EARLY ELECTIVE DELIVERY DENIAL OVERRIDDEN	N661 (01/01/21)	Documentation does not support that the services rendered were medically necessary.
50 (06/18/07)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1804	CLAIM CHECK: COSMETIC PROCEDURE	N383 (01/01/14)	Not covered when deemed cosmetic.
50 (06/18/07)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1807	CLAIM CHECK: PROCEDURE CODE IS COSMETIC AND UNLISTED	N383 (01/01/14)	Not covered when deemed cosmetic.
50 (01/29/16)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2221	INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT		
50 (01/29/16)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2222	INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMT QUALIFIER		



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50 (01/29/16)	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2223	INV/MISSING OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		
51 (01/01/16)	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1603	ADJ/VOID CREATED FOR RECIPIENT CHANGE FROM GA TO OTHER ELIG	N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
52 (01/01/13)	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	1386	PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - BILLING	N95 (02/01/16)	This provider type/provider specialty may not bill this service.
55 (11/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0234	PEND FOR OUT-OF-STATE NON-DRG PRICING POLICY CHANGE	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
55 (11/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0458	OCCURRENCE CODE INDICATES ACCIDENT REVIEW REQUIRED	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
55 (04/01/15)	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1810	CLAIM CHECK: PROCEDURE CODE IS EXPERIMENTAL	M49 (01/01/14)	Missing/incomplete/invalid value code(s) or amount(s).
56 (01/29/16)	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2249	GERIATRIC PRECAUTION FOUND-DRUG IS ON BEERS/HEDIS/STOPP LIST		
57 (05/02/11)	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	1300	MAXIMUM DAILY DOSAGE EXCEEDED: CHECK DRUG QTY	M123 (01/01/14)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.



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58 (01/01/14)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0236	PROCEDURE/PLACE OF SERVICE RESTRICTION	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
58 (08/01/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1007	SUD PLACE OF SERVICE RESTRICTION	N115 (08/01/16)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
58 (01/29/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2220	INVALID FACILITY NAME FOR FACILITY ID		
58 (01/29/16)	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2247	FACILITY ID IS MISSING OR INVALID		
59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0759	PAYMENT REDUCED - SURGERY/ANESTHESIA CONFLICT	N633 (01/01/14)	Additional anesthesia time units are not allowed.
59 (11/01/15)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0901	MULTIPLE SURGERY-PAID AS PRIMARY PROCEDURE	N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0902	MULTIPLE SURGERY-PAID AS SECONDARY PROC, MAX 200% OF PRIMARY	N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.



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59 (01/01/14)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0903	MULT SURG - PRIME PROC FEE REDUCED BY PRIOR PAID CLAIM	N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
59 (11/01/15)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0904	MULTIPLE SURGERY-\$0 PAID, LIMIT EXCEEDED	N670 (11/01/15)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
59 (10/16/03)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0907	MULT SURG- 1ST UNIT PRIMARY, ADDT'L AS SECONDARY - 200% MAX	N670 (01/01/14)	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
59 (01/29/16)	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2134	PSYCHOTROPIC DRUGS-FIVE OR MORE USED CONCURRENTLY		
62 (10/16/03)	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	0937	PRIOR AUTHORIZED UNITS USED FOR CLAIM PAYMENT	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.	0844	ADJUSTMENT CLAIM MISSING PAYOR CODE AND/OR PRIOR PAYMENT	N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
65 (04/01/18)	Procedure code was incorrect. This payment reflects the correct code.	0846	ADJUSTMENT MUST HAVE RA ATTACHED	N10 (04/01/18)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
92 (05/02/11)	Claim Paid in full.	1301	MAXIMUM DAILY DOSAGE NOT FOUND	M123 (05/02/11)	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
92 (06/01/10)	Claim Paid in full.	1608	INITIAL DETERMINATION OF PURCHASE	M7 (01/01/14)	No rental payments after the item is purchased, returned or after the total of issued rental payments equals the purchase price.
95 (02/01/16)	Plan procedures not followed.	0197	MISSING/INVALID NCPDP MAND		
95 (01/03/16)	Plan procedures not followed.	0431	OTHER PAYOR ID REQUIRED WITH TPL PAYMENT		



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95 (01/03/16)	Plan procedures not followed.	0433	"POSSIBLE UNDERUTILIZATION; MEP UNIT TO CONTACT MD"		
95 (01/03/16)	Plan procedures not followed.	0478	NO LONGER ACCEPT PAPER COMPOUND CLAIMS		
95 (02/01/16)	Plan procedures not followed.	0512	DRUG NOT PAYABLE - NO ADDP REBATE AGREEMENT		
95 (01/29/16)	Plan procedures not followed.	0879	MEDICARE / PAAD ADJUSTMENT		
95 (01/29/16)	Plan procedures not followed.	0880	CUMULATIVE RETRO REVIEW - FOR INTERNAL USE.		
95 (11/28/16)	Plan procedures not followed.	1448	SERVICE NOT RELATED TO TERMINAL COND FOR HOSPICE BENEFICIARY	N629 (11/28/16)	Reviews/documentation/notes/summaries/reports/charts not requested.
95 (10/20/14)	Plan procedures not followed.	1618	MEDICARE PART A REQUIRED FOR MN HOSPICE SERVICES	M79 (10/20/14)	Missing/incomplete/invalid charge.
95 (01/01/16)	Plan procedures not followed.	2005	MEDICARE PART D DEDUCTIBLE AMT MUST BE BETWEEN 0 AND 250.00		
95 (01/01/16)	Plan procedures not followed.	2006	PART D COINS/COPAY AMT IS A NEGATIVE NUMBER		
95 (01/01/16)	Plan procedures not followed.	2019	PART D COINS/COPAY + DEDUCTIBLE CANNOT BOTH BE ZERO		
95 (01/01/16)	Plan procedures not followed.	2021	PART D WRAPAROUND WITH PA		
95 (01/01/16)	Plan procedures not followed.	2022	PART D CLAIM FOR BENE WITH MULTI ELIG - RESUBMIT WITH ALT ID#		
95 (01/01/16)	Plan procedures not followed.	2029	PART D PAPER CLAIM NOT ALLOWED FOR PART D COB CLAIMS		
95 (01/29/16)	Plan procedures not followed.	2115	AWP WITH PRE-SETTLEMENT FORMULA LESS THAN AWP ON FILE		
95 (01/29/16)	Plan procedures not followed.	2122	PARTD DEDUCTIBLE INVALID FOR TITLE XIX BENEFICIARY		
95 (01/29/16)	Plan procedures not followed.	2127	HMS AUDIT B1 REPLACEMENT CLAIM, ORIG CLM NOT AUDITED BY HMS		
95 (01/29/16)	Plan procedures not followed.	2129	HMS AUDIT ADJUSTMENT REASON 42/47 ADDED TO POS HISTORY CLAIM		



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95 (01/29/16)	Plan procedures not followed.	2226	INVALID CLAIM FORMAT-NCPDP D.0 IS IN MANDATORY PERIOD		
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0009	SERVICES NOT COVERED FOR THIS RECIPIENT.	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0116	INVALID LEAVE OF ABSENCE DATE	N43 (10/16/03)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0117	LEAVE OF ABSENCE DATE(S) OUTSIDE DATES OF SERVICE	N43 (10/16/03)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0118	LEAVE OF ABSENCE FROM/THRU DATE CONFLICT	N43 (10/16/03)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0121	MCARE BED HOLD BEGIN DATE OUTSIDE DATES OF SERVICE	N43 (10/16/03)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0122	MCARE BED HOLD END DATE OUTSIDE DATES OF SERVICE	N43 (10/16/03)	Bed hold or leave days exceeded.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0126	COMPOUND DRUG INDICATOR INVALID	N163 (11/01/15)	Medical record does not support code billed per the code definition.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0223	PROVIDER ON REVIEW-DENY PAYMENT	N35 (11/01/15)	Program integrity/utilization review decision.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0263	NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE	N30 (10/16/03)	Patient ineligible for this service.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0266	NOT AN SAI COVERED SERVICE	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0270	ROUTINE IMMUNIZATION FOR HEPTITIS "A" IS NON-COVERED SERVICE	N216 (01/01/14)	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0279	DENIED AS A RESULT OF PREPAYMENT REVIEW BY DMAHS	M87 (10/16/03)	Claim/service(s) subjected to CFO-CAP prepayment review.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0280	POS PAID CLAIM, PAYMENT PENDING	N35 (11/01/15)	Program integrity/utilization review decision.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0285	HOSPICE RECIPIENT IS NOT MEDICARE ELIGIBLE	N12 (11/01/15)	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0301	RECIPIENT INELIG ON DATES OF SERVICE	N30 (10/16/03)	Patient ineligible for this service.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0304	PRESUMPTIVELY ELIGIBLE RECIPIENT (NON-COVERED)	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0305	CCPED OR HCEP NON COVERED SERVICE	N30 (01/01/14)	Patient ineligible for this service.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0308	INELIGIBLE SERVICES UNDER MEDICALLY NEEDY PROGRAM	N30 (09/01/20)	Patient ineligible for this service.



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96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0309	GSHP OUT-OF-PLAN SERVICE- RECIPIENT INELIGIBLE FOR MEDICAID	N30 (01/01/14)	Patient ineligible for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0315	HOSPICE ELECTION REVIEW	N35 (10/16/03)	Program integrity/utilization review decision.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0316	LOCK-IN AUTHORIZATION FORM INCORRECT OR INCOMPLETE	N35 (11/01/15)	Program integrity/utilization review decision.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0350	GENERAL ASSISTANCE-SERVICE NOT COVERED.	N30 (10/16/03)	Patient ineligible for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0358	SECOND OPINION - DATE RESTRICTION	N129 (11/01/15)	Not eligible due to the patient's age.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0359	SECOND OPINION DATE AND AGE RESTRICTION	N129 (11/01/15)	Not eligible due to the patient's age.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0365	GA RECIPIENT NOT ON RECIP HISTORY MASTER FILE	N30 (10/16/03)	Patient ineligible for this service.
96 (11/04/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0370	PLAN H - BENEFICIARY - NON-COVERED SERVICE.	N30 (11/03/03)	Patient ineligible for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0371	CSOCI - UNABLE TO DETERMINE COVERAGE	N30 (11/01/15)	Patient ineligible for this service.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0373	CSOCI - NON-COVERED SERVICE	N30 (10/16/03)	Patient ineligible for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0375	SPECIAL STATE AUTO PEND	N35 (10/16/03)	Program integrity/utilization review decision.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0379	SPEC PGM UNABLE TO DETERMINE COVERAGE	N35 (10/16/03)	Program integrity/utilization review decision.



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96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0385	NON-COVERED SERVICE FOR PROGRAM STATUS CODE	N30 (10/16/03)	Patient ineligible for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0424	ELIG ENDED BEFORE CLAIM THRU DATE FOR DME-CUTBACK APPLIED	N622 (11/01/15)	Not covered based on the date of injury/accident.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0426	NO FQHC ENCOUNTER WITH DELIVERY HCPCS CLAIM PAID AT NON-ZERO	N35 (11/01/15)	Program integrity/utilization review decision.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0432	THIS LEGEND DRUG NOT COVERED BY PAAD/SG	N30 (10/16/03)	Patient ineligible for this service.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0450	DRUG NOT COVERED FOR ESRD RECIPIENT	N30 (10/16/03)	Patient ineligible for this service.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0451	MEDICAL SUPPLY OR SERVICE(S) NOT COVERED FOR ESRD RECIPIENT	N30 (10/16/03)	Patient ineligible for this service.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0455	RECIPIENT NOT ELIGIBLE ON FROM D.O.S. NO DEDUCTIBLE DUE	N408 (11/01/15)	This payer does not cover deductibles assessed by a previous payer.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0456	LAB NOT COVERED FOR ESRD RECIPIENT	N30 (10/16/03)	Patient ineligible for this service.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0509	MEDICARE BED HOLD INVALID	N43 (11/01/15)	Bed hold or leave days exceeded.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0532	NON LEGEND DRUG NOT COVERED FOR PAAD/SR GOLD BENEFICIARIES	N30 (10/16/03)	Patient ineligible for this service.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0534	DRUG NOT PAYABLE FEDERAL/IRS DESI	N30 (10/16/03)	Patient ineligible for this service.
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0552	ADDP-SERVICE NOT COVERED.	N30 (10/16/03)	Patient ineligible for this service.



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96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0556	COMPOUND DRUG NOT COVERED		
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0557	COMPOUND DRUG NOT COVERED FOR PAAD RECIPIENT		
96 (10/16/03)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0561	COMPOUND DRUG NOT COVERED FOR LTC RECIPIENT	N30 (10/16/03)	Patient ineligible for this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0562	COMP DRUG WITH INGREDIENT NOT COVERED BY REBATE AGREEMENT		
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0570	DRUG NOT PAYABLE - NO STATE REBATE AGREEMENT		
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0573	CAPITATION RATE NOT ON FILE	N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.



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96 (05/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0629	PATIENT LIABILITY CONFLICT - PAYMENT REDUCED	N174 (05/01/16)	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0667	COMPUTED DRUG COST ALLOW IS ZERO - VERIFY/CORRECT QUANTITY	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0698	COINSURANCE DAYS EXCEED MEDICARE MAXIMUM OF 30 DAYS	N58 (09/01/20)	Missing/incomplete/invalid patient liability amount.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0699	LIFETIME RESERVE DAYS EXCEED MEDICARE MAXIMUM OF 60 DAYS	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0700	CONFLICTING SAME DAY LAB SERVICE	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0712	CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM-DENY	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.



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96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0716	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0718	HOSPITAL LEAVE OF ABSENCE EXCEEDS LIMIT	N43 (01/01/14)	Bed hold or leave days exceeded.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0719	THERAPEUTIC LEAVE OF ABSENCE EXCEEDS LIMIT	N43 (01/01/14)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0724	DATE(S) OF SERVICE DO NOT MATCH LAB PANEL PROCEDURE EFF DATE	N56 (01/01/14)	Procedure code billed is not correct/valid for the services billed or the date of service billed.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0730	SPECIMEN COLLECTION GREATER THAN ONE	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0735	INITIAL VISIT/ANNUAL EXAM/EPSDT EXAM LIMIT	N666 (01/01/14)	Only one evaluation and management code at this service level is covered during the course of care.



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96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0739	TRANSPORT CLAIM MUST PAY FIRST	N157 (01/01/14)	Transportation to/from this destination is not covered.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0747	PROPHYLAXIS LIMIT	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
96 (01/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0790	INVALID ADJUSTMENT LOCATOR	N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
96 (01/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0833	CLAIM FOR CONTINUOUS LEAVE- NO PRIOR SERVICE DATE PAID CLAIM	N43 (01/01/16)	Bed hold or leave days exceeded.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0884	CLAIM DENIED/SUBMIT DME CLAIM TO MEDICARE	N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0900	ZERO PAYMENT - INFORMATIONAL EPSDT CLAIM ONLY	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0925	UTILIZATION REVIEW APPROVAL MISSING/INCORRECT/DENIED	N35 (01/01/14)	Program integrity/utilization review decision.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0930	BED-HOLD EXCEEDS MAXIMUM OF 10 CONSECUTIVE DAYS	N43 (01/01/14)	Bed hold or leave days exceeded.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0932	THERAPEUTIC LEAVE EXCEEDS MAXIMUM OF 24 CONSECUTIVE DAYS	N43 (01/01/14)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0933	THERAPEUTIC LEAVE CUTBACK TO 24 DAYS MAXIMUM	N43 (11/01/15)	Bed hold or leave days exceeded.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0934	BED-HOLD CUTBACK TO 10 DAY MAXIMUM	N43 (01/01/14)	Bed hold or leave days exceeded.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0936	INPATIENT RESPITE CARE EXCEEDS MAXIMUM OF 5 CONSECUTIVE DAYS	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0939	RECIPIENT IS MEDICARE PART A ELIGIBLE	M28 (10/16/03)	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0945	'CARE ASSIGNMENT NOT ACCEPTED - CLAIM NOT PAYABLE BY 'CAID	N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0953	CLAIM VOIDED - SERVICE BILLED INCORRECTLY	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0958	DENIED ACCORDING TO MEDICAID/MEDICAL REVIEW GUIDELINES	N109 (08/01/15)	Alert: This claim/service was chosen for complex review.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0962	ADJUSTMENT OR VOID CORRESPONDS TO PROVIDER REFUND	MA131 (01/01/14)	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0963	RECIPIENT HAS MEDICARE - BILL MEDICARE	N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .



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96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0970	BILL THIRD PARTY CARRIER OR MEDICARE HMO FIRST	N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0979	RECIPIENT IS MCARE PART B OR MCARE HMO ELIGIBLE	N104 (01/01/14)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
96 (11/29/21)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1038	PROVIDER NOT COVERED FOR OORP SERVICES	N9 (11/29/21)	Adjustment represents the estimated amount a previous payer may pay.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1248	NO BED HOLD/THERAPEUTIC LEAVE PAYMT FOR NURSING FACILITY	N43 (07/01/07)	Bed hold or leave days exceeded.
96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1337	ASC PROCEDURE SERVICE	N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
96 (02/01/16)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1388	MEDICARE HMO DEDUCTIBLE EXCEEDS YEARLY MAXIMUM	N408 (02/01/16)	This payer does not cover deductibles assessed by a previous payer.



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96 (05/15/17)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1447	RECIPIENT INELIGIBLE FOR CSOC RESPITE SERVICE	N30 (05/15/17)	Patient ineligible for this service.
96 (06/26/17)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1453	INCORRECTLY BILLED SVC; REQUIRES HH MOD, CCBHC SVC/PROV	N95 (06/26/17)	This provider type/provider specialty may not bill this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1600	CLAIM EXCEEDS BEDS LICENSED TO PROVIDER FOR THE MONTH	N54 (01/01/14)	Claim information is inconsistent with pre-certified/authorized services.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1609	LONG TERM PSYCHIATRIC CLAIM REDUCED BY PR1	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1614	OBSERVATION OFFICE VISIT CONFLICT WITH OTHER DENTAL SERVICE	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1624	PAYMENT AMOUNT WAS REDUCED DUE TO PATIENT LIABILITY	N174 (01/01/14)	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.



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96 (11/01/15)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1627	EXHAUSTED CHARGES A3 AMOUNT REPORTED ON THE CLAIM	N587 (11/01/15)	Policy benefits have been exhausted.
96 (01/01/14)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1632	PROVIDER ADULT MDC UNIT EXCEEDS 200 UNIT PER DAY	M139 (01/01/14)	Denied services exceed the coverage limit for the demonstration.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1670	NUMBER OF UNITS EXCEEDS 6 IN A 14 DAY PERIOD	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2034	MEDICARE PART D - NOT COVERED AS WRAPAROUND BENEFIT		
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2035	INVALID PDP REJECT CODE FOR PART D WRAPAROUND BENEFIT	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2151	RX IS A COMPOUND, NOT BILLED AS A COMPOUND	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.



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96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2323	DAILY MORPHINE MILLIGRAM EQUIVALENT > 50	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
96 (09/01/20)	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2324	DAILY MORPHINE MILLIGRAM EQUIVALENT EXCEEDED	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0392	PROCEDURE CODE MAPPED TO LOCAL CODE FOR PROCESSING PURPOSES	N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
97 (12/27/04)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0427	FQHC DELIVERY HCPCS MINUS ENCOUNTER RATE.	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0483	LAB TEST INCLUDED IN ESRD COMPOSITE RATE	M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (10/16/03)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0664	ITEM BILLED IS INCLUDED IN ADMINISTRATION/SUPPLY KIT	M97 (10/16/03)	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0670	NO PAYMENT DUE-MEDICARE PAYMENT EXCEEDS MEDICAID ALLOWABLE	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.



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97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0703	EPISIOTOMY INCLUDED IN DELIVERY CHARGE	M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0713	LAB TEST CONFLICT/LAB PANEL PROCEDURE PREVIOUSLY PAID	M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0714	LAB TEST CONFLICT, INDIVIDUAL TEST(S) PREVIOUSLY PAID	M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0729	CLAIM PAYMENT REDUCED FOR PREVIOUSLY PAID VISIT	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0741	PROCEDURE DENIED - COMPONENT PREVIOUSLY PD CLAIM	M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0745	HOSPITAL CALL/CONSULTATION CONFLICT	N637 (01/01/14)	Consultations are not allowed once treatment has been rendered by the same provider.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0805	INPATIENT AND HOME HEALTH DUPLICATE ERROR	N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.



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97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0806	LTC AND HOME HEALTH DUPLICATE ERROR	N111 (11/01/15)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0840	EXACT DUPLICATE WITHIN GROUP PRACTICE	N111 (01/01/14)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0906	MULTIPLE SURGERY - \$0 PAID, INCIDENTAL PROCEDURE	N19 (01/01/14)	Procedure code incidental to primary procedure.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0950	RE-PROCESSED PREVIOUSLY DENIED CLAIM	M15 (11/01/15)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/29/16)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0964	ADJUSTMENT OR VOID CORRESPONDS TO CANCELLED MMIS CHECK	N432 (01/29/16)	Alert: Adjustment based on a Recovery Audit.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0968	PROCEDURE CODE DOES NOT ACCURATELY REFLECT SERVICES RENDERED	N22 (08/01/15)	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1348	HMS AUDIT - ADJUSTMENT/VOID REQUEST DENIED	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.



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97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1367	HMS COMMERCIAL TPL RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1368	HMS COMMERCIAL TPL RECOVERY-PROVIDER ADJUSTMENTS ALLOWED	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1369	HMS CREDIT BALANCE RECOVERY - EXCESS PAY	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1370	HMS CREDIT BALANCE RECOVERY - READMISSION	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1371	HMS CREDIT BALANCE RECOVERY - TRANSFER	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1372	HMS CREDIT BALANCE RECOVERY - DUPLICATE PAYMENT	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1373	HMS MEDICARE RECOVERY-NO FURTHER PROVIDER ADJUSTMENTS	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.



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97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1374	HMS MEDICARE RECOVERY - PROVIDER ADJUSTMENTS ALLOWED	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1376	HMS RAC RECOVERY - NO FURTHER PROVIDER ADJUSTMENTS	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.
97 (11/01/15)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1377	HMS RAC RECOVERY PROVIDER ADJUSTMENTS ALLOWED	N432 (11/01/15)	Alert: Adjustment based on a Recovery Audit.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1615	CUTBACK-OBSERVATION OFFICE VISIT ALREADY PAID	M80 (01/01/14)	Not covered when performed during the same session/date as a previously processed service for the patient.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1815	CLAIM CHECK: DUPLICATE PROCEDURE FOR SAME DATE OF SERVICE	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1818	CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING	M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1878	CLAIM CHECK: MEDICALLY UNLIKELY EDIT (EXCESSIVE UNITS)	N111 (01/01/13)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.



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97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1890	CLAIM CHECK: POST OPERATIVE PROCEDURE CODE	M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1891	CLAIM CHECK: PRE OPERATIVE PROCEDURE CODE	M144 (06/18/07)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1892	CLAIM CHECK: PROCEDURE NOT VALID DUE TO REBUNDLING	M15 (01/01/14)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
97 (01/01/14)	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1895	CLAIM CHECK: DUPLICATE PROCEDURE	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
106 (10/16/03)	Patient payment option/election not in effect.	0531	LTC/HOSPICE REQUIRES PR-1 OR LTC REQUIRES PATIENT PYT AMOUNT	M97 (10/16/03)	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
107 (04/01/18)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0533	OTC DRUG COST INCLUDED IN NF PER DIEM	N65 (04/01/18)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0564	NO VOLUME DISCOUNT ON FILE FOR CLAIM SERVICE DATE	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0565	OTC DRUG NO UNIT PRICE ON FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.



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107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0566	OTC DRUG NO PACKAGE PRICE ON FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0567	TEAMCARE DRUG NO UNIT PRICE ON FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0568	TEAMCARE DRUG NO PACKAGE PRICE ON FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
107 (10/16/03)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0569	LEGEND DRUG NO PACKAGE PRICE ON FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
107 (11/01/15)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0666	UNABLE TO PRICE CLAIM	MA66 (11/01/15)	Missing/incomplete/invalid principal procedure code.
107 (01/01/16)	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0785	MAINFRAME CLAIM NOT PRESENT ON POS HISTORY		
108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0849	RENTAL DENIED/PRIOR PURCHASE WITHIN 24 MONTHS	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0851	DME RENTAL LIMIT 6 IN 24 MONTHS EXCEEDED	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0852	DME RENTAL LIMIT 10 IN 24 MONTHS EXCEEDED	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.



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108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0853	PURCHASE DENIED/6 PRIOR RENTALS WITHIN 24 MONTHS	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0854	PURCHASE DENIED/10 PRIOR RENTALS IN 24 MONTHS	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
108 (01/01/14)	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0855	PURCHASE DENIED/PRIOR PURCHASE WITHIN 24 MONTHS	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0391	PREMIUM SUPPORT - BILL OTHER INSURANCE	N36 (11/01/15)	Claim must meet primary payer's processing requirements before we can consider payment.
109 (10/16/03)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0400	NOT VALID CAPITATION CLAIM	N418 (11/01/15)	Misrouted claim. See the payer's claim submission instructions.
109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0402	NOT COVERED BY GA - BILL ADDP		
109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0438	PAYOR ID QUALIFIER DOES NOT EQUAL 99 PBM LIST		
109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0439	INVALID OTHER PAYOR ID CODE NOT ON PBM LIST		
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0484	ESRD POSSIBLY ELIGIBLE FOR MEDICARE	N104 (10/16/03)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0645	MISSING NEW YORK EXEMPT FACILITY RATE DATE	N538 (11/01/15)	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	0682	SERVICE/PRODUCT NOT ELIGIBLE UNDER MEDICAID PROGRAM	N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .
109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1006	CLAIM IS 100% MEDICARE-COVERED - NO MEDICAID PAYMENT DUE	N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov .



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109 (11/01/15)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1836	CLAIM CHECK: CLAIM WAS BYPASSED	N104 (11/01/15)	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
109 (02/01/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1899	CLAIM CHECK: BYPASS CLAIM CHECK	M104 (02/01/16)	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	2089	DIABETIC SUPPLIES NOT COVERED - BILL MCARE PT B OR OTH TPL		
109 (01/29/16)	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	2236	PARTD PDP ON CLAIM AND NO BENEFIT STAGES SUBMITTED		
110 (01/01/14)	Billing date predates service date.	0021	BILLED DATE LESS THAN THRU DATE	N622 (01/01/14)	Not covered based on the date of injury/accident.
110 (01/01/14)	Billing date predates service date.	0023	BILLED DATE < STATEMENT THRU DATE	N622 (01/01/14)	Not covered based on the date of injury/accident.
110 (01/01/14)	Billing date predates service date.	0490	INPATIENT DATE OF SURGERY < SERVICE FROM DATE	N622 (01/01/14)	Not covered based on the date of injury/accident.
110 (01/01/14)	Billing date predates service date.	0529	CLAIM DATES OF SERVICE BEFORE INITIAL ASSESSMENT DATE	N622 (01/01/14)	Not covered based on the date of injury/accident.
114 (01/01/16)	Procedure/product not approved by the Food and Drug Administration.	2119	NON-COVERED NDC PER CMS/FDA RESTRICTION		
117 (10/16/03)	Transportation is only covered to the closest facility that can provide the necessary care.	0633	AMBULANCE/INVALID COACH < 16 MILES	M69 (10/16/03)	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0148	RESPIRE CARE EXCEEDS MAXIMUM OF 5 DAYS	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0276	UTILIZATION EXCEEDS ESTABLISHED PARAMETERS	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0289	PAYMENT BASED ON THE PLACE OF SERVICE	N45 (11/01/15)	Payment based on authorized amount.
119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.	0403	DURATION AT THIS DOSAGE EXCEEDED	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	0526	PA-3L INCOME GREATER THAN PATIENT PAYMENT AMOUNT PA-3L USED	N45 (10/16/03)	Payment based on authorized amount.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	0610	MANUAL PRICING EXCEEDS BILLED CHARGES	M139 (01/01/16)	Denied services exceed the coverage limit for the demonstration.



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119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0672	SPLIT CLAIM RECIP ELIG ON DISCHARGE DATE ONLY-NO PMT DUE	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0673	SPLIT CLAIM ALL ELIG DAYS ARE RESIDENTIAL-NO PAYMENT DUE	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0674	SPLIT CLAIM SNF/ICF DAYS AT/BELOW DRG HIGH TRIM-NO PMT DUE	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0675	SPLIT CLAIM NJ HIV OUTLIER CLAIM-SNF/ICF DAYS NOT PAYABLE	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0701	DUPLICATE CONSULTATION	N111 (01/01/14)	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0702	SERVICE CONFLICTS WITH SIMILAR SAME DAY PROCEDURE	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0705	CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - PA REQUIRED	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0706	30 DAY NEONATAL CARE LIMIT	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0707	60 DAY NEONATAL CARE LIMITATION	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0715	MENTAL HEALTH SERVICES OVER \$400-NF/BOARDING HOME	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0717	PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED	N587 (11/01/15)	Policy benefits have been exhausted.
119 (09/01/20)	Benefit maximum for this time period or occurrence has been reached.	0720	TARGETED CASE MANAGEMENT LIMIT EXCEEDED	N362 (09/01/20)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0721	CONFLICTING TARGETED CASE MANAGEMENT SERVICE	M90 (01/01/14)	Not covered more than once in a 12 month period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0731	THREE YEAR XRAY LIMITATION EXCEEDED	N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0733	CLAIM EXCEEDS LIMIT OF ONE UNIT OF SERVICE	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0734	SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0736	LAB SERVICE	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.



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119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0737	PAAD/SR GOLD RECIP REFILL > 12 MO FROM ORIGINAL PRESCRIPTION	M90 (01/01/14)	Not covered more than once in a 12 month period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0738	REFILL EXCEEDS PROGRAM MAXIMUM	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0740	OPT APP EXCEEDS PROGRAM LIMITATION	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0748	ORAL EXAMINATION LIMIT	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	0755	EARLY REFILL	M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	0757	DRUG SUPPLIED EARLY BY DIFFERENT PROVIDERS	M80 (10/16/03)	Not covered when performed during the same session/date as a previously processed service for the patient.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0760	NORPLANT EXCEED 2 IN 5 YEARS - SAME PROVIDER	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0761	NORPLANT EXCEEDS 2 IN 5 YEARS - DIFFERENT PROVIDER	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0762	MENTAL HEALTH SERVICES EXCEED \$900	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0764	PARTIAL CARE AND FULL DAY NOT PAYABLE ON SAME DAY	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0765	DELIVERY/ABORTION PROCEDURE LIMITS	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0766	WAIVER SERVICE CONFLICT	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0767	PARTIAL CARE/MEDICATION MANAGEMENT CONFLICT	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0834	TBI COUNSELING EXCEEDS \$600/MNTH	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0835	TBI TRANSPORTATION EXCEEDS \$100/WK	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0836	TBI ENVIRONMENTAL MOD EXCEEDS \$5000/MNTH	N130 (01/01/14)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0837	TBI BEHAVIOR PROGRAM EXCEEDS UNITS OF SERVICE	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.



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HIPAA Adjustment Reason Code (Mapping Last Change Date)	HIPAA Adjustment Reason Code Description	NJMMIS Edit Code	NJMMIS Edit Code Description	HIPAA Remark Code (Mapping Last Change Date)	HIPAA Remark Code Description
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0857	WEEKLY PERSONAL CARE ASSISTANCE/MENTAL HEALTH HRS EXCEED 25	N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0858	WEEKLY PERSONAL CARE ASSISTANT (PCA) SVCS HOURS EXCEED 40	N435 (01/01/14)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0859	CLAIM OVERLAPS CALENDAR WORK WEEK-SUN.12:00AM TO SAT.11:59PM	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	0872	FAMILYCARE THERAPY SERVICE LIMITS	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0873	KIDCARE D MENTAL HEALTH SERVICE FOR BENEFIT YEAR EXCEEDED	M90 (01/01/14)	Not covered more than once in a 12 month period.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	0875	FISCAL YEAR FUNDS EXHAUSTED	N587 (01/01/14)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	0910	PAYMENT EXCEEDS THRESHOLD	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	0918	DAILY DOSAGE EXCEEDS MAXIMUM RECOMMENDED DOSAGE	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
119 (10/16/03)	Benefit maximum for this time period or occurrence has been reached.	0938	VOIDED CLAIM EXCEEDS PROGRAM LIMITS	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.	0990	DELAYED PAYMENT OF PROPRIETARY ELECTRONIC CLAIM	N381 (01/29/16)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1012	VALUE OF ONE OR MORE OF THESE FIELDS WAS > MAX ALLOWED	N362 (11/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.	1014	DDD SELF DIRECTED INSUFFICIENT PA FUNDING TO FULFILL CLAIM	N587 (04/01/18)	Policy benefits have been exhausted.
119 (04/01/18)	Benefit maximum for this time period or occurrence has been reached.	1015	DDD/IME CLAIM MODIFIERS DO NOT MATCH PA MODIFIERS	N587 (04/02/18)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1207	PAYMENT PENDING SFY JULY 1 APPROPRIATION	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1210	PART A EXHAUSTED CHARGES IS GREATER THAN 99,999.99	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1255	MEDICARE SUP CLAIM W/O EXHAUSTED DATE OR CHARGES	N587 (11/01/15)	Policy benefits have been exhausted.



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119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1256	MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY	N587 (11/01/15)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1257	MCARE SUPPL CLM W/EXHAUSTED CHRGS NO PAT LIABILITY	N587 (11/01/15)	Policy benefits have been exhausted.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1335	PAYMENT REDUCED TO SUL PRICE	N45 (11/01/15)	Payment based on authorized amount.
119 (01/29/16)	Benefit maximum for this time period or occurrence has been reached.	1606	RATE DECREASE WHEN PARTIAL HOSPITALIZATION EXCEEDS 24 MONTH	N362 (01/29/16)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	1623	OUTPATIENT ACUTE ADULT PARTIAL HOSPITALIZATION TIME EXCEEDED	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	1630	MCARE LTC CLAIM WITH OVERLAPPING DOS	M86 (01/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
119 (06/01/14)	Benefit maximum for this time period or occurrence has been reached.	1649	OP TRANS PMT REDUCED BY PREVIOUS PAID OP TRANS CLM	N362 (06/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/14)	Benefit maximum for this time period or occurrence has been reached.	1652	MENTAL HEALTH CLAIM CUTBACK - BENEFIT LIMIT REACHED	N362 (01/01/14)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (01/01/21)	Benefit maximum for this time period or occurrence has been reached.	1702	DOULA VISITS EXCEED LIMIT	N435 (01/01/21)	Exceeds number/frequency approved /allowed within time period without support documentation.
119 (07/01/22)	Benefit maximum for this time period or occurrence has been reached.	1711	SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
119 (11/22/22)	Benefit maximum for this time period or occurrence has been reached.	1713	DIABETES SERVICES EXCEED LIMIT	M53 (11/22/22)	Missing/incomplete/invalid days or units of service.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	1805	CLAIM CHECK: CLAIM LINES EXCEED MAXIMUM	N362 (01/01/16)	The number of Days or Units of Service exceeds our acceptable maximum.
119 (11/01/15)	Benefit maximum for this time period or occurrence has been reached.	1858	CLAIM CHECK: CLAIM LINES EXCEED THE MAXIMUM	N640 (01/01/16)	Exceeds number/frequency approved/allowed within time period.
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	2028	CLAIM PAYMENT THRESHOLD EXCEEDS \$25000 / 125000		
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	2030	PART D CO-PAYMENT/CO-INSURANCE EXCEEDS ANNUAL AMT		
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	2031	PART D CO-PAYMENT/CO-INSURANCE EXCEEDS ANNUAL AMT		
119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	2040	MEDICARE PART D CO-PAYMENT EXCEEDS MAX ALLOWED.		



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119 (01/01/16)	Benefit maximum for this time period or occurrence has been reached.	2042	COPAY EXCEEDS CHARGE FOR 3 MONTH SUPPLY FOR RECIP LIS LEVEL		
119 (04/01/17)	Benefit maximum for this time period or occurrence has been reached.	2297	CLAIM SUBMITTED AS A 340B CLAIM	N45 (04/01/17)	Payment based on authorized amount.
128 (01/01/16)	Newborn's services are covered in the mother's Allowance.	1239	MOTHER OF NEWBORN HAS SERVICE IN-PLAN		
129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0476	NO CLAIM IN HISTORY FILE MATCHES ADJ/VOID REQUEST	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0488	DRG INTERIM BILL APPROVAL REQUIRED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0516	EPSDT FFS INCENTIVE PAYMENT ERROR	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0517	PASARR RECORD MISSING	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0518	INVALID PASARR DATA	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0787	ADJUSTMENT CLAIM TYPE NOT MATCHED	N48 (01/01/14)	Claim information does not agree with information received from other insurance carrier.
129 (01/01/16)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0794	FINANCIAL CORRECTION REQUIRED	MA130 (01/01/16)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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129 (10/16/03)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0798	HISTORY RECORD ALREADY ADJUSTED OR VOIDED	N9 (10/16/03)	Adjustment represents the estimated amount a previous payer may pay.
129 (11/01/15)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0869	POSSIBLE (SEVERE) DD CONFLICT - 30 DAY EXIT	MA130 (11/01/15)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1205	ADJUSTMENT/VOID DOES NOT MATCH RECIPIENT ID ON CLAIM	MA36 (01/01/14)	Missing/incomplete/invalid patient name.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1249	MISSING PRIMARY PAYER IDENTIFICATION	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1250	MISSING SECONDARY PAYER IDENTIFICATION	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1251	MISSING TERTIARY PAYER IDENTIFICATION	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1253	SUM OF SUBMITTED DEDUCT, COINS OR CO-PAY EXCEEDS APPR AMT	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
129 (01/01/14)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1254	INVALID PRIMARY BENEFITS EXHAUST DATE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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129 (05/04/21)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1466	REPROCESSED AT THE REQUEST OF MFD - WITHOUT A UD MODIFIER	MA67 (05/04/21)	Alert: Correction to a prior claim.
129 (03/20/23)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1470	RECYCLED AFTER CHANGE OF OWNERSHIP - ALM 3708	MA67 (03/20/23)	Alert: Correction to a prior claim.
129 (07/01/20)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1688	CLM FOR REQUIRED BASE TIME CODE NOT RECEIVED FOR ADD ON CODE	N702 (07/01/20)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
129 (01/01/21)	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1752	NO PRESUMPTIVE DRUG TEST WITHIN 7 DAYS	N702 (01/01/21)	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0541	COMPOUND DRUG MANUAL REVIEW REQUIRED	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0550	PENDING FOR REVIEW OF DRUG FILE ENTRY	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0563	NO BASE DISPENSING FEE ON FILE FOR CLAIM SERVICE DATE	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0603	PROVIDER NOT ON DRG RATE FILE	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0617	CALCULATED PAYMENT AMOUNT ZERO	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0651	MISSING PENNSYLVANNIA DRG RATE DATA	N35 (10/16/03)	Program integrity/utilization review decision.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0652	MISSING NEW YORK DRG RATE DATA	N35 (10/16/03)	Program integrity/utilization review decision.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0653	MISSING NY DRG SERVICE INTENSITY WEIGHT	N35 (10/16/03)	Program integrity/utilization review decision.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0654	MISSING NY DRG OUTLIER PERCENT	N35 (10/16/03)	Program integrity/utilization review decision.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0655	MISSING NEW YORK DRG ALC PER DIEM RATE	N35 (10/16/03)	Program integrity/utilization review decision.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0656	MISSING NJ DRG MARKUP FACTOR	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.



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133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0992	SET LOCATION TO STATE REVIEW	MA07 (10/16/03)	Alert: The claim information has also been forwarded to Medicaid for review.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	0996	NO APPROP CODES ASSIGNED FOR CREDIT RECORD	N29 (10/16/03)	Missing documentation/orders/notes/summary/report/chart.
133 (04/01/15)	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	1333	PLEASE CONTACT THE MANAGE CARE OFFICE AT 1-800-701-0710	MA07 (11/08/10)	Alert: The claim information has also been forwarded to Medicaid for review.
140 (01/01/16)	Patient/Insured health identification number and name do not match.	2128	6-DIGIT ICN ON HMS AUDIT CLAIM DOES NOT MATCH NJMMIS CLAIM		
141 (01/01/14)	Claim spans eligible and ineligible periods of coverage.	0620	RECIPIENT NOT ELIGIBLE FOR FULL SERVICE PERIOD: CUTBACK	MA31 (08/31/04)	Missing/incomplete/invalid beginning and ending dates of the period billed.
146 (11/01/15)	Diagnosis was invalid for the date(s) of service reported.	0296	DIAGNOSIS CODE NOT ON FILE	M76 (11/01/15)	Missing/incomplete/invalid diagnosis or condition.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	0919	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ	MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	0920	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA	MA63 (01/01/14)	Missing/incomplete/invalid principal diagnosis.
146 (06/18/07)	Diagnosis was invalid for the date(s) of service reported.	1801	CLAIM CHECK: CLM DIAG INVALID BASED ON ICD-9 EXPIRATION DT	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.	1802	CLAIM CHECK: CLM DIAGNOSIS INVALID ICD-10	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	1843	CLAIM CHECK: INVALID DIAGNOSIS CODE	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (01/01/14)	Diagnosis was invalid for the date(s) of service reported.	1847	CLAIM CHECK: INVALID DIAGNOSIS CODE	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.	1879	CLAIM CHECK: DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DT	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.



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146 (12/12/07)	Diagnosis was invalid for the date(s) of service reported.	1880	CLAIM CHECK: DIAGNOSIS INVALID ICD-10	M76 (06/18/07)	Missing/incomplete/invalid diagnosis or condition.
147 (10/16/03)	Provider contracted/negotiated rate expired or not on file.	0619	VALID RATE FOR LEVEL-OF-CARE NOT FOUND ON RATE FILE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
150 (10/16/03)	Payer deems the information submitted does not support this level of service.	0540	COMPOUND DRUG FOR GSHP BENEFICIARY	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
150 (10/16/03)	Payer deems the information submitted does not support this level of service.	0544	DRUG NOT PAYABLE FEDERAL DESI	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
150 (10/16/03)	Payer deems the information submitted does not support this level of service.	0555	PAAD RECIP INELIGIBLE FOR MEDICAID SERVICES	N30 (10/16/03)	Patient ineligible for this service.
150 (01/01/16)	Payer deems the information submitted does not support this level of service.	0792	ADJUSTMENT TO CONVERTED CLAIM	N10 (01/01/16)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
150 (11/01/15)	Payer deems the information submitted does not support this level of service.	1279	CALCULATED PAYMENT AMOUNT ZERO	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
150 (01/01/15)	Payer deems the information submitted does not support this level of service.	1341	INVALID REVENUE CODE FOR OUTPATIENT OBSERVATION SERVICES	M50 (01/01/15)	Missing/incomplete/invalid revenue code(s).
150 (01/29/16)	Payer deems the information submitted does not support this level of service.	2073	REQUESTOR IS NOT AUTHORIZED TO VOID/ADJUST THIS CLAIM		
151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	0710	UNABLE TO DETERMINE LEAVE PERIOD-ADJUSTMENT MAY BE REQUIRED	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
151 (09/01/20)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	0791	ADJUSTMENT REQUIRES MANUAL UPDATE	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	0793	ADJUSTMENT PENDED FOR ARCHIVE CYCLE	N10 (04/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.



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151 (01/01/16)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	0843	ADJUSTMENT REQUEST NEEDS TO BE MORE SPECIFIC	M25 (02/01/16)	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1013	OP XOVER PR RE-PRICING	M25 (11/01/15)	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
151 (11/01/15)	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1611	PARTIAL PR-1 DEDUCTION APPLIED	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
153 (10/16/03)	Payer deems the information submitted does not support this dosage.	0413	2 PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION	N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.
153 (10/16/03)	Payer deems the information submitted does not support this dosage.	0414	1 PRESCRIPTION REMAINS WITHOUT NEED FOR PRIOR AUTHORIZATION	N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.
153 (04/01/18)	Payer deems the information submitted does not support this dosage.	0415	NO PRESCRIPTIONS REMAIN WITHOUT NEED FOR PRIOR AUTHORIZATION	N59 (04/01/18)	Alert: Please refer to your provider manual for additional program and provider information.
153 (01/03/16)	Payer deems the information submitted does not support this dosage.	0463	UNIT RECAPTURE ADJUSTMENTS		
153 (01/01/16)	Payer deems the information submitted does not support this dosage.	2046	PRESCRIPTION NOT ALLOWED DUE TO CHANGE IN THERAPY		



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153 (01/29/16)	Payer deems the information submitted does not support this dosage.	2132	ANTIPSYCHOTIC DRUG-56 DAYS AT MAX DOSE REQ BEFORE SWITCHING		
153 (01/29/16)	Payer deems the information submitted does not support this dosage.	2133	ANTIPSYCHOTIC DRUG-OVERLAPPING USAGE OF 2+ DRUGS > 42 DAYS		
154 (02/01/16)	Payer deems the information submitted does not support this day's supply.	0395	INITIAL PRESCRIPTION LIMITED TO A 34 DAY SUPPLY		
154 (01/29/16)	Payer deems the information submitted does not support this day's supply.	0396	REFILL RX LIMITED TO 34 DAYS / 100 UNITS		
154 (01/01/14)	Payer deems the information submitted does not support this day's supply.	0548	DAYS SUPPLY EXCEEDS PROGRAM MAX	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.	0196	TIMELY FILING EDIT BYPASSED DUE TO CONSENT ORDER	N3 (01/01/16)	Missing consent form.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0199	SUBMIT HARD COPY CLAIM AND MEDICARE EOB	N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0239	ALTERED DOCUMENTATION-ORIGINAL PRICE LIST/INVOICE NEEDED	N445 (11/01/15)	Missing document for actual cost or paid amount.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0335	ABORTION CERTIFICATION FORM REQUIRED	MA130 (04/01/18)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0336	ABORTION REQUIRES REVIEW	M60 (11/01/15)	Missing Certificate of Medical Necessity.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0337	STERILIZATION FORM REQUIRES REVIEW	M60 (11/01/15)	Missing Certificate of Medical Necessity.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0341	INSUFFICIENT MEDICAL DOCUMENTATION FOR ABORTION	M127 (11/01/15)	Missing patient medical record for this service.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0354	HYSTERECTOMY REQUIRES ATTACHMENT	N398 (11/01/15)	Missing elective consent form.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0452	CERTIFICATION OF EMERGENCY FORM MISSING/INVALID	N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0453	PA/CERT DATES OR RECIPIENT ID# CONFLICT WITH CLAIM	N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0471	FQHC ENCOUNTER WITH NO PD HCPCS ON HIST	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).



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163 (01/01/16)	Attachment/other documentation referenced on the claim was not received.	0842	ADJUSTMENT MUST HAVE CORRECTED CLAIM ATTACHED	N706 (01/01/16)	Missing documentation.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	0878	NO EMERGENCY CLAIM FOR ALIEN TRANSPORTATION CLAIM	N391 (11/01/15)	Missing emergency department records.
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	0980	EOB ATTACHED FOR CARRIER/PAYER NOT REPORTED ON CLAIM	N4 (10/16/03)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	1610	NO MATCH FOUND IN HISTORY FOR HOSPITAL ADJUSTMENT	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (11/01/15)	Attachment/other documentation referenced on the claim was not received.	1628	REQUIRED DENTAL CLAIM NOT RECEIVED FOR SAME DOS	N279 (11/01/15)	Missing/incomplete/invalid pay-to provider name.
163 (06/26/17)	Attachment/other documentation referenced on the claim was not received.	1675	CCBHC ENCOUNTER WITH NO PD CCBHC ON HIST	N214 (06/26/17)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (07/01/21)	Attachment/other documentation referenced on the claim was not received.	1709	OORP WEEKLY SERVICE(X4) WITH NO PD INIT SVC (X3)	N214 (07/01/21)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (01/01/22)	Attachment/other documentation referenced on the claim was not received.	1710	INCK SCREENING & NO PAID ANNUAL OR E&M VISIT PAID	N214 (01/01/22)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	2096	PATIENT PAID AMOUNT UNKNOWN - 433-DX	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	2110	PATIENT PAID AMOUNT UNKNOWN		
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	2124	PA NUMBER FIELD CONTAINING AUDIT DATA REQUIRED FOR HMS AUDIT		
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	2210	NO SIGNATURE ON CLAIM LOG		
163 (01/29/16)	Attachment/other documentation referenced on the claim was not received.	2212	INVOICE IS ILLEGIBLE		
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	0026	CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING LIMITS	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	0027	INPATIENT CLAIM W/O ATTACHMENT EXCEEDS TIMELY FILING LIMITS	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	0029	MEDICARE CROSSOVER CLAIM EXCEEDS TIMELY FILING LIMIT	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	0076	CLAIM W/ATTACH EXCEEDS TIMELY FILING	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.



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164 (04/01/18)	Attachment/other documentation referenced on the claim was not received in a timely fashion.	0077	I/P CLAIM EXCEEDS TIMELY FILING LIMIT	N584 (11/01/15)	Not covered based on the insured's noncompliance with policy or statutory conditions.
166 (01/01/15)	These services were submitted after this payers responsibility for processing claims under this plan ended.	1347	MLTSS WAIVER FFS CLAIM REPROCESS.	N663 (01/01/15)	Adjusted based on an agreed amount.
166 (01/29/16)	These services were submitted after this payers responsibility for processing claims under this plan ended.	2277	VOID RECEIVED AFTER HOURS-HELD UNTIL POS SYSTEM AVAILABLE		
167 (11/01/15)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0332	STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21	N30 (11/01/15)	Patient ineligible for this service.
167 (11/01/15)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0881	URO/DRG AUDIT ADJUST - REQUEST DENIED	N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).
167 (01/01/14)	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0924	DISCHARGE DATE AND READMIT DATE WITHIN SET TIME SPANS FOR NY	N647 (01/01/14)	Adjusted based on diagnosis-related group (DRG).
169 (01/29/16)	Alternate benefit has been provided.	2228	PAYER-PAT DATA FOR HEALTH PLAN FUNDED ASSISTANCE(129-UD) > 0		
169 (01/29/16)	Alternate benefit has been provided.	2276	BNFT STG 90-NOT PARTD CLM-OTC/ENH-NO TROOP BUT PTD COVERED		
170 (11/01/15)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0696	CLAIM DENIED PROVIDER NOT REENROLLED	M143 (11/01/15)	The provider must update license information with the payer.
170 (11/01/15)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1326	INVALID PROVIDER TYPE FOR ATTENDING PROVIDER	N95 (04/02/10)	This provider type/provider specialty may not bill this service.
170 (01/15/13)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1383	INVALID PROVIDER TYPE - OPERATING 1	N95 (11/01/15)	This provider type/provider specialty may not bill this service.



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170 (01/15/13)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1384	INVALID PROVIDER TYPE - OPERATING 2 PHYSICIAN	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
170 (02/01/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1385	PROV NOT APPROVED FOR SERVICE TO MEDICAID CLIENT - SERVICING	N95 (02/01/16)	This provider type/provider specialty may not bill this service.
170 (02/20/17)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1452	NON-MEDICAID PROVIDER NOT ELIGIBLE FOR SERVICE	N95 (02/20/17)	This provider type/provider specialty may not bill this service.
170 (08/06/18)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1455	NOT A COVERED SERVICE UNDER NJ MEDICAID	N95 (08/06/18)	This provider type/provider specialty may not bill this service.
170 (01/29/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2177	INELIGIBLE PHARMACY		
170 (01/29/16)	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2270	PROVIDER ONLY AUTHORIZED TO PRESCRIBE- NOT A BILLING PROV		
173 (01/29/16)	Service/equipment was not prescribed by a physician.	2176	INELIGIBLE PRESCRIBER BASED ON CMS LIST		
173 (01/29/16)	Service/equipment was not prescribed by a physician.	2190	RETURNED TO STOCK PRESCRIPTION		
174 (01/29/16)	Service was not prescribed prior to delivery.	2194	RX DISPENSED AFTER DATE OF DEATH		
174 (01/29/16)	Service was not prescribed prior to delivery.	2205	RU DIRECTIONS FOR USE MISSING		
174 (01/29/16)	Service was not prescribed prior to delivery.	2206	TPL CLAIM FOR PATIENT WITH PART D - SHOULD BE PART D CLAIM		



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175 (01/01/16)	Prescription is incomplete.	0447	DAILY DOSE EXCEEDS REC.LIMITS FOR DRUG FOUND IN COMBO PROD.		
175 (01/03/16)	Prescription is incomplete.	0466	COMPOUND CLAIM WITH ONLY ONE INGREDIENT		
175 (01/29/16)	Prescription is incomplete.	0756	DRUG SUPPLIED EARLY - REVIEW REQUIRED		
175 (01/29/16)	Prescription is incomplete.	0890	EARLY REFILL-SAME PROVIDER - DENIED AFTER REVIEW		
175 (01/29/16)	Prescription is incomplete.	0891	EARLY REFILL-SAME PROVIDER WITH NO ATTACHMENT 08		
175 (01/29/16)	Prescription is incomplete.	0897	EARLY REFILL-DIFFERENT PROVIDER-DENIED AFTER REVIEW		
175 (01/29/16)	Prescription is incomplete.	0898	EARLY REFILL-DIFFERENT PROVIDER WITH NO ATTACHMENT 08		
175 (03/01/21)	Prescription is incomplete.	1707	COVID VACCINE ADMINISTRATION CONFLICT	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (03/01/21)	Prescription is incomplete.	1708	MINIMUM DAYS REQUIRED BETWEEN VACCINE DOSES	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (01/01/16)	Prescription is incomplete.	2001	COMPOUND CONTAINS DUPLICATE INGREDIENTS		
175 (01/01/16)	Prescription is incomplete.	2002	LTC COMPOUND MUST CONTAIN ACTUAL NDC		
175 (01/01/16)	Prescription is incomplete.	2003	COMPOUND DRUG-INCORRECT INGREDIENT QUANTITY/COST		
175 (01/01/16)	Prescription is incomplete.	2024	PART D DRUG EMERGENCY SUPPLY - ONE TIME ONLY		
175 (01/01/16)	Prescription is incomplete.	2026	PART D EMERGENCY SUPPLY OF ANTIBIOTICS - FULL PRESCRIPTION		
175 (01/01/16)	Prescription is incomplete.	2047	PA REQUIRED: DRUG / PRESCRIBER RESTRICTION		



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175 (12/13/22)	Prescription is incomplete.	2138	ANONYMOUS NALOXONE BUDGET LIMIT EXCEEDED FOR THE FY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (01/29/16)	Prescription is incomplete.	2143	MINIMUM 180 DAYS REQUIRED FOR VACCINATION CLAIM		
175 (09/01/20)	Prescription is incomplete.	2153	RX INCORRECTLY SUBMITTED AS A COMPOUND	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	2154	INITIAL CONTROLLED DRUG FILLED > 30 DAYS PAST DATE WRITTEN	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	2156	RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCRBR NPI	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	2162	RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS PRESCR INFO	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	2166	INCORRECT COMPOUND INGREDIENT NDC# SUBMITTED	N668 (09/01/20)	Incomplete/invalid prescription.
175 (09/01/20)	Prescription is incomplete.	2175	NO NAME ON RX	N668 (09/01/20)	Incomplete/invalid prescription.
175 (01/29/16)	Prescription is incomplete.	2182	RX INCOMPLETE; MISSING DATE WRITTEN		
175 (01/29/16)	Prescription is incomplete.	2184	RX INCOMPLTE; MISSING MORE THAN ONE REQUIRED COMPONENT		
175 (01/29/16)	Prescription is incomplete.	2185	RX INCOMPLETE, MISSING PRESCR INFO/PRESCR SIG/AUTH AGENT/DEA		
175 (01/29/16)	Prescription is incomplete.	2186	RX IS INCOMPLETE-PAT NAME IS AMBIG/INCOMPLETE		
175 (01/29/16)	Prescription is incomplete.	2187	RX INCOMPLETE; MISSING DIRECTIONS, DRUG NAME, STRENGTH/QTY		
175 (01/29/16)	Prescription is incomplete.	2188	RX/DOCUMENTATION IS ILLEGIBLE		
175 (01/29/16)	Prescription is incomplete.	2193	MISSING/INCOMPLETE SIGNATURE/DELIVERY LOG/CERTIF STATEMENT		
175 (01/29/16)	Prescription is incomplete.	2207	RX INCOMPLETE/MISSING/AMBIG/INCOMPLETE PRESCRIBER SIGNATURE		



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175 (01/29/16)	Prescription is incomplete.	2208	RX INCOMPLETE-MISSING/INCOMPLETE/AMBIGUOUS QUANTITY		
175 (01/29/16)	Prescription is incomplete.	2209	SIGNATURE OR DELIVERY LOG IS INCOMPLETE		
175 (01/29/16)	Prescription is incomplete.	2285	COMPOUND INGREDIENT DRUG COST IS NON-NUMERIC OR NEGATIVE		
175 (04/01/17)	Prescription is incomplete.	2296	CLAIM NOT ELIGIBLE FOR 340B PRICING	M86 (04/01/17)	Service denied because payment already made for same/similar procedure within set time frame.
175 (01/29/16)	Prescription is incomplete.	2302	344-HF QUANTITY INTENDED TO BE DISPENSED IS NOT NUMERIC		
175 (01/29/16)	Prescription is incomplete.	2303	345-HG DAYS SUPPLY INTENDED TO BE DISPENSED IS NOT NUMERIC		
175 (01/29/16)	Prescription is incomplete.	2304	600-28 UNIT OF MEASURE NOT VALID VALUE (EA/GM/ML)		
175 (01/29/16)	Prescription is incomplete.	2306	442-E7 QUANTITY DISPENSED NOT NUMERIC OR IS NEGATIVE		
175 (01/29/16)	Prescription is incomplete.	2307	414-DE PRESCRIPTION DATE IS NOT NUMERIC		
175 (01/29/16)	Prescription is incomplete.	2308	335-2C PREGNANCY INDICATOR IS NOT 1, 2 OR BLANK		
175 (01/29/16)	Prescription is incomplete.	2309	409-D9 INGREDIENT COST IS NOT NUMERIC OR GREATER THAN ZERO		
175 (01/29/16)	Prescription is incomplete.	2310	412-DC DISPENSING FEE SUBMITTED IS NOT NUMERIC		
175 (01/29/16)	Prescription is incomplete.	2311	466-EZ PRESCRIBE QUALIFIER ID IS NOT VALID VALUE 01,05 OR 08		
175 (01/29/16)	Prescription is incomplete.	2312	411-DB PRESCRIBER ID IS BLANK OR NOT SUBMITTED		
175 (01/29/16)	Prescription is incomplete.	2313	406-D6 COMPOUND CODE IS NOT 1 OR 2		
175 (01/29/16)	Prescription is incomplete.	2314	407-D7 INVALID COMBINATION OF NDC, CMPND NDC OR CMPND CODE		
175 (01/29/16)	Prescription is incomplete.	2315	488-RE COMPOUND PRODUCT ID QUALIFIER IS NOT 03		



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175 (01/29/16)	Prescription is incomplete.	2319	202-B2 SERVICE PROVIDER ID QUALIFIER NOT 01		
175 (01/29/16)	Prescription is incomplete.	2320	455-EM PRESCRIPTION/SERVICE REFERENCE NUM QUALIFIER IS NOT 1		
175 (01/29/16)	Prescription is incomplete.	2321	436-E1 PROD/SERV ID QUAL NOT 03 FOR SINGLE OR 00 FOR CMPND		
175 (01/29/16)	Prescription is incomplete.	2322	492-WE DIAGNOSIS CODE QUALIFIER IS NOT 01, 02, 00 OR BLANK		
175 (01/29/16)	Prescription is incomplete.	2326	301-C1 GROUP ID IS NOT BLANK		
175 (09/01/20)	Prescription is incomplete.	2331	DATE RX WRITTEN > 30 DAYS OLD SCHED II-V	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2332	DATE RX WRITTEN > 365 DAYS OLD NON SCHED DRUG	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2333	460-ET QTY PRESCRIBED NOT NUMERIC OR NOT SUBMITTED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2334	QTY PRESCRIBED DOES NOT MATCH PREVIOUSLY SUBMITTED CLAIM	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2335	QTY DISPENSED > QTY PRESCRIBED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2336	NUM OF REFILLS AUTH > O SCHED II	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2337	403-3D FILL NUMBER M/I	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.



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175 (09/20/20)	Prescription is incomplete.	2338	403-D3 NUMBER > O ON SCHED II	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2340	343-HD DISPENSING STATUS INVALID	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2342	ACCUM OF MED EXCEEDS 30 DAYS SUPPLY	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (09/20/20)	Prescription is incomplete.	2350	DATE RX WRITTEN > 30 DAYS OLD SCHED II - V	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
175 (02/28/22)	Prescription is incomplete.	2351	OTC COVID TEST EXCEEDED- LIMIT 4 KITS PER MONTH	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
176 (01/29/16)	Prescription is not current.	0416	PRESCRIPTION VOLUME EXCEEDS THRESHOLD - PA REQUIRED		
177 (01/03/16)	Patient has not met the required eligibility requirements.	0449	"INAPPROPRIATE NARCOTIC USE"		
177 (01/01/16)	Patient has not met the required eligibility requirements.	2004	CLAIM PENDING RE-ENROLLMENT		
181 (11/01/15)	Procedure code was invalid on the date of service.	0253	REVENUE/PROCEDURE NOT VALID ON DATE(S) OF SERVICE	N657 (11/01/15)	This should be billed with the appropriate code for these services.
181 (01/01/16)	Procedure code was invalid on the date of service.	0597	VERIFY OR CORRECT PROC CODE/NDC FOR DATE(S) OF SERVICE	N517 (01/01/16)	Resubmit a new claim with the requested information.
183 (04/02/10)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1325	INVALID PROVIDER TYPE FOR REFERRING PROVIDER	N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
183 (01/23/12)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1336	INVALID REFERRING PROVIDER FOR PLACE OF SERVICE 2 OR 4	N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.



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183 (01/15/13)	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1391	REFERRING PROVIDER INELIGIBLE ON DATES OF SERVICE	N630 (11/01/15)	Referral not authorized by attending physician.
184 (01/01/14)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0546	PAAD/SR GOLD CLAIM SUBMITTED BY OUT-OF-STATE PROVIDER	N950 (07/12/21)	
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0885	NON PAR. PHARM PROV SERV W/PA 6/01/01 PAAD/ SENIOR GOLD		
184 (11/01/15)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1382	INVALID PROVIDER TYPE - PRESCRIBING PHYSICIAN	N574 (11/01/15)	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
184 (01/15/13)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1390	PRESCRIBING PROVIDER INELIGIBLE ON DATES OF SERVICE	N267 (01/01/13)	Missing/incomplete/invalid ordering provider secondary identifier.
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2174	PRESCRIPTION NOT VALID FOR DOS		
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2179	INAPPROPRIATE PRESCRIBER		
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2266	INELIGIBLE PRESCRIBER, 15-DAY GRACE PERIOD BEGINS FOR RECIP		



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184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2267	GRACE PERIOD LIMITED TO 30 DAYS SUPPLY FOR NORMAL SOLID DOSE		
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2268	INELIGIBLE PRESCRIBER, PRESCRIPTION IN 15-DAY GRACE PERIOD		
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2269	INELIGIBLE PRESCRIBER-OUTSIDE GRACE PERIOD, NO FILLS ALLOWED		
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2271	PROVIDER NOT AUTHORIZED TO PRESCRIBE AS PER ACA REQUIREMENT		
184 (01/29/16)	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2272	PRESCRIBER NPI MAPS TO GROUP NUMBER- PRESCRIBER MUST BE INDIV		
185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0203	PROVIDER ON REVIEW - STATE PEND	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0243	PROVIDER NOT AUTHORIZED-TARGETED CASE MANAGEMENT	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.



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185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0281	POS VOID TRANSACTION FOR PROVIDER-ON-REVIEW	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0282	POS PROVIDER ON REVIEW-NO Z NO OVERRIDE	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0691	PROVIDER NOT PARTICIPATING IN REQUIRED PGM ON DATE OF SERVIC	N381 (11/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
185 (11/01/15)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0697	CLAIM PENDED PROVIDER RE-ENROLLMENT NOT COMPLETED	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
185 (11/07/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1424	NO ASSOCIATION FOUND FOR DDD-SP/CCW SVC LOCATION NPI	M58 (03/07/05)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
185 (11/07/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1429	DDD-SP/CCW SVC LOCATION NPI IS INELIGIBLE FOR DOS	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
185 (07/16/12)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1647	REVENUE CODE INVALID FOR LONG TERM PSYCH CLAIMS	M50 (11/01/15)	Missing/incomplete/invalid revenue code(s).
185 (01/01/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2117	INCORRECT BILLING PROVIDER NUMBER FOR INSTITUTIONAL SERVICES		



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185 (01/29/16)	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2248	FACILITY ID NOT ON FILE FOR ACTIVE LTC PROVIDER		
188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.	0870	POSSIBLE WARFARIN CONFLICT		
188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.	0877	SEVERE DD INTERACTION; PA REQUIRED FOR DIFFERENT PRESCRIBERS		
188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.	0916	SEVERE DRUG/DRUG INTERACTION DUR		
188 (01/29/16)	This product/procedure is only covered when used according to FDA recommendations.	0917	MODERATE DRUG/DRUG INTERACTION DUR	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
194 (01/01/14)	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	0758	SURGERY/ANESTHESIA CONFLICT - ANESTHESIA DENIED	M80 (01/01/14)	Not covered when performed during the same session/date as a previously processed service for the patient.
197 (01/29/16)	Precertification/authorization/notification/pre-treatment absent.	2284	DRUG SUBJECT TO MEDICAL REVIEW		
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	0410	SERVICE NOT AUTHORIZED BY GSHP CASE MANAGER	N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0772	PA/PROVIDER NOT AUTHORIZED	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0773	DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE(S)	N531 (01/01/14)	Not qualified for recovery based on direct payment of premium.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0774	PRIOR AUTHORIZATION NOT ON FILE	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0775	PA RECORD ON FILE IS NOT ACTIVE	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.	0776	PA DOLLARS/UNITS EXHAUSTED-CUTBACK	N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	0777	GSHP PA ALREADY PROCESSED	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0779	MEDICAID PRIOR AUTHORIZATION NUMBER INVALID	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.



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198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0780	GSHP PRIOR AUTHORIZATION NOT ON FILE	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0781	GSHP PRIOR AUTHORIZATION RECORD NOT ACTIVE	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0782	GSHP DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATE	N351 (01/01/14)	Service date outside of the approved treatment plan service dates.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0783	GSHP PROCEDURE NOT INCLUDED IN PRIOR AUTHORIZATION	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (09/01/20)	Precertification/notification/authorization/pre-treatment exceeded.	0784	GSHP PRIOR AUTHORIZED UNITS/DOLLARS EXHAUSTED	N54 (09/01/20)	Claim information is inconsistent with pre-certified/authorized services.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0867	PCA SERVICES > 25 HRS. & VALID PA NUMBER NOT ON CLAIM.	M62 (01/01/14)	Missing/incomplete/invalid treatment authorization code.
198 (01/01/14)	Precertification/notification/authorization/pre-treatment exceeded.	0868	PCA UNITS OF SERVICE EXCEEDS WEEKLY ALLOWABLE ON THE PA.	M62 (01/02/14)	Missing/incomplete/invalid treatment authorization code.
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	0926	AUTHORIZATION PERIOD FOR ORTHO SVCS EXCEEDED/ PA REQUIRED	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.
198 (11/01/15)	Precertification/notification/authorization/pre-treatment exceeded.	1617	PA NUMBER CHANGED SYSTEMATICALLY	N54 (11/01/15)	Claim information is inconsistent with pre-certified/authorized services.
199 (11/01/15)	Revenue code and Procedure code do not match.	0058	INV/MISS PROCEDURE CODE/REVENUE CODE/CHARGE	N657 (11/01/15)	This should be billed with the appropriate code for these services.
199 (11/01/15)	Revenue code and Procedure code do not match.	0665	PROCEDURE DESCRIPTION DOES NOT MATCH PRICE LIST	N657 (11/01/15)	This should be billed with the appropriate code for these services.
199 (03/29/10)	Revenue code and Procedure code do not match.	1328	BILL OUTPATIENT DRUG CLAIMS USING REVENUE CODES 631 THRU 637	N657 (11/01/15)	This should be billed with the appropriate code for these services.
199 (07/01/25)	Revenue code and Procedure code do not match.	1475	INVALID REVENUE CODE FOR SUBSTANCE ABUSE	N657 (07/01/25)	This should be billed with the appropriate code for these services.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	0303	RECIPIENT IS SERVICE OR PROVIDER RESTRICTED	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	0310	GSHP RECIPIENT - NOT ELIGIBLE FOR LTC SERVICES	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	0404	DURATION STANDARD EXCEEDED - POSSIBLE CUTBACK	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	0446	DRUG NOT COVERED BY CF PROGRAM		



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204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	0535	DAILY QUANTITY EXCEEDED - 30 DAY EXTENSION PERIOD AUTHORIZED	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	0536	DAILY QUANTITY POSSIBLY EXCEEDED	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	0537	DAILY DRUG QUANTITY EXCEEDED; IMMEDIATE PA REQUIRED	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	0538	DAILY METRIC QUANTITY EXCEEDS DUR STANDARD/AGE	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	0615	DRG NOT EFFECTIVE ON CLAIM SERVICE DATE	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (10/01/19)	This service/equipment/drug is not covered under the patient's current benefit plan	1011	NOT A FAMILY PLANNING SVC/NOT ATTESTED PLANNING SVC	N30 (10/01/19)	Patient ineligible for this service.
204 (11/01/15)	This service/equipment/drug is not covered under the patient's current benefit plan	1216	DRUG REBATE INDICATOR ZERO OR NO MCAID/GA REBATE AGREEMENT	N448 (11/01/15)	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan	1407	NOT A COVERED SERVICE UNDER MSP FOR SLMB OR QI	N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/10/22)	This service/equipment/drug is not covered under the patient's current benefit plan	1467	NOT A COVERED SERVICE UNDER MSP FOR QMB	N130 (01/10/22)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	2032	DAILY DRUG QUANTITY EXCEEDS APPROVED AMOUNT	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2033	PAAD/SG/ADDP CLAIMS ONLY - PAID CLAIMS FOR NON PART D DRUG		
204 (02/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2044	PART D-EMERGENCY SUPPLY MAY BE FILLED ONLY ONCE IN 90 DAYS		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2109	DRUG NOT PAYABLE DUE TO CHANGE IN COVERAGE RULES		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2111	NOT COVERED FOR RELIEF OF COUGH AND COLD SYMPTOMS		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2121	OTC NOT ON MEDICAID PART D WRAPAROUND		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2125	DRUG NOT COVERED FOR ADDP LIMITED COVERAGE PROGRAM		
204 (01/01/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2131	CMS UNMATCHED NDC ACCORDING TO FDB EDITORIAL (BLENDED) INFO		



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204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2135	EDI AGREEMENT REQUIRED FOR NCPDP D.O CLAIM	M44 (04/05/11)	Missing/incomplete/invalid condition code.
204 (09/01/20)	This service/equipment/drug is not covered under the patient's current benefit plan	2157	DOC HAS NO DIRECTIONS (SIG) FOR USE/EXCESSIVE QTY OF DAYS	N130 (09/01/20)	Consult plan benefit documents/guidelines for information about restrictions for this service.
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2225	INVALID OTHER COVERAGE CODE FOR NCPDP D.O CLAIM		
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2232	BENEFIT STAGE AMOUNT SUBMITTED FOR DEDUCTIBLE STAGE		
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2233	BENEFIT STAGE AMOUNT SUBMITTED FOR INITIAL STAGE		
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2234	BENEFIT STAGE AMOUNT SUBMITTED FOR DONUT HOLE STAGE		
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2235	BENEFIT STAGE AMOUNT SUBMITTED FOR CATASTROPHIC STAGE		
204 (01/29/16)	This service/equipment/drug is not covered under the patient's current benefit plan	2237	OTHER PAYER-PATIENT RESP AMT COUNT NOT EQUAL # REPETITIONS		
204 (11/20/20)	This service/equipment/drug is not covered under the patient's current benefit plan	2343	NDC PRICING EXCEEDS CLASS AVG; CHANGE NDC OR PA NEEDED	MA130 (01/01/14)	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
206 (11/01/15)	National Provider Identifier - missing.	0949	CLAIM VOIDED - BILLING PROVIDER ERROR	N253 (11/01/15)	Missing/incomplete/invalid attending provider primary identifier.
207 (11/01/15)	National Provider identifier - Invalid format	0212	SERV PROV NOF/ LTC COTTAGE NUMBER INVALID	N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.
208 (11/01/15)	National Provider Identifier - Not matched.	0216	SERVICING (INDIVIDUAL) PROVIDER NUMBER REQUIRED	N262 (11/01/15)	Missing/incomplete/invalid operating provider primary identifier.
208 (11/01/15)	National Provider Identifier - Not matched.	0217	LTC PROVIDER NOT ELIGIBLE FOR ENTIRE PERIOD:CUTBACK	N77 (11/01/15)	Missing/incomplete/invalid designated provider number.
208 (08/16/10)	National Provider Identifier - Not matched.	1329	HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION	N77 (08/16/10)	Missing/incomplete/invalid designated provider number.
208 (08/16/10)	National Provider Identifier - Not matched.	1334	HEALTHCARE PRVDR FEDERALLY EXCLUDED FROM NJMM PARTICIPATION	N77 (08/16/10)	Missing/incomplete/invalid designated provider number.
210 (01/01/14)	Payment adjusted because pre-certification/authorization not received in a timely fashion	0409	PROSTHETIC AND/OR ORTHOTIC CHARGES REQUIRES PA	M62 (10/16/03)	Missing/incomplete/invalid treatment authorization code.



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212 (01/01/16)	Administrative surcharges are not covered	2137	PART D COPAY NOT COVERED AS OF FY2012		
222 (01/29/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0407	THERAPEUTIC DUPE; CLAIM THRESHOLD EXCEEDED		
222 (01/03/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0441	NUMBER OF UNITS RESTOCKED EXCEEDS ORIGINAL UNITS PAID		
222 (01/03/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0442	ORIGINAL CLAIM INELIGIBLE FOR UNIT DOSE RESTOCKING/RECYCLING		
222 (01/01/14)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0768	EXCESSIVE PRIVATE DUTY NURSING HOURS-PA REQUIRED	N640 (01/01/14)	Exceeds number/frequency approved/allowed within time period.
222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0829	EARLY REFILL -SAME PROVIDER - DENIED AFTER REVIEW		
222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0830	EARLY REFILL - SAME PROVIDER WITH NO ATTACHMENT 08		
222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0831	EARLY REFILL - DIFFERENT PROVIDER - DENIED AFTER REVIEW		



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222 (01/01/16)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0832	EARLY REFILL - DIFFERENT PROVIDER WITH NO ATTACHMENT 08		
222 (01/01/15)	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1651	MAX UNITS REACHED FOR 2 CONSECUTIVE DAY OCCURRENCE	N362 (01/01/15)	The number of Days or Units of Service exceeds our acceptable maximum.
224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	2197	UNDOCUMENTED AUTHORIZATION OF REFILL		
224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	2198	STOLEN PRESCRIPTION PAD		
224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	2199	ACQUISITION NON-MATCH (NDC)		
224 (01/29/16)	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	2200	MISSING ACQUISITION RECORD		
226 (01/01/14)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0417	GENERIC SUBSTITUTION REQUIRED OR INAPPROPRIATE DAW	M44 (10/16/03)	Missing/incomplete/invalid condition code.
226 (01/01/14)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0530	LTC OVERLAPPING LEAVE PERIODS	MA31 (10/16/03)	Missing/incomplete/invalid beginning and ending dates of the period billed.



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226 (05/02/11)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1349	VERIFY METRIC QUANTITY REPORTED	N378 (05/02/11)	Missing/incomplete/invalid prescription quantity.
226 (12/07/20)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1459	PRA INVALID- NO RECIPIENT FOUND FOR PRENATAL SERVICE	N705 (12/07/20)	Incomplete/invalid documentation.
226 (08/17/21)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1464	PRA INVALID-NO BILLING NPI NUM FOUND FOR PRENATAL SERVICE	N705 (08/17/21)	Incomplete/invalid documentation.
226 (08/17/21)	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1465	PRA INVALID - CLAIM DOS NOT WITHIN PRA DOS	N705 (08/17/21)	Incomplete/invalid documentation.
231 (11/01/15)	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0722	SERVICE/VISIT CONFLICT	N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
233 (01/01/14)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1340	PROVIDER PREVENTABLE CONDITION - NOT COVERED	N567 (05/01/16)	Not covered when considered preventative.
233 (12/09/13)	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1401	PAYMENT ADJUSTED FOR HOSPITAL ACQUIRED CONDITION	N647 (11/01/15)	Adjusted based on diagnosis-related group (DRG).
234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0486	PHARMACY {DRUGS} INCLUDED IN ESRD COMPOSITE RATE	M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.



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234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0487	MEDICAL SUPPLIES INCLUDED IN THE ESRD COMPOSITE RATE	M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0746	MASS ADJ: BILLED CHARGES MODIFIED TO PERMIT ADJ-SEE REC-569	M15 (11/01/15)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1322	SERVICE/PROCEDURE INCLUDED IN COMPOSITE RATE	N676 (11/01/15)	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1605	FQHC PAID HIGHEST DELIVERY, OB/GYN OR ENCOUNTER CLAIM	M15 (11/01/15)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
234 (11/01/15)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1655	SERVICE/VISIT CONFLICT	N628 (11/01/15)	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
234 (01/29/16)	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	2195	QUANTITY BILLED IS GREATER THAN THE QUANTITY DELIVERED		
236 (11/01/15)	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	0725	BIOPSY D&C CONFLICT	N657 (11/01/15)	This should be billed with the appropriate code for these services.
238 (09/01/14)	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	1408	HOSPICE CUTBACK DAY OF REVOCATION	MA31 (09/01/14)	Missing/incomplete/invalid beginning and ending dates of the period billed.
238 (06/29/15)	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	1409	HOSPICE DATE OF DEATH PAYMENT CUTBACK	MA31 (06/29/15)	Missing/incomplete/invalid beginning and ending dates of the period billed.



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240 (11/01/15)	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0043	INV/MISS BIRTH WEIGHT	N207 (11/01/15)	Missing/incomplete/invalid weight.
242 (01/01/14)	Services not provided by network/primary care providers.	0219	PROVIDER NOT AUTHORIZED PARTIAL CARE/PARTIAL HOSPITALIZATION	N95 (10/16/03)	This provider type/provider specialty may not bill this service.
242 (01/01/14)	Services not provided by network/primary care providers.	0221	PROVIDER NOT CERTIFIED/BONDED AT TIME OF SERVICE	N95 (08/31/04)	This provider type/provider specialty may not bill this service.
242 (01/01/14)	Services not provided by network/primary care providers.	0690	PROVIDER NOT PARTICIPATING IN REQUIRED PROGRAM.	N95 (01/28/05)	This provider type/provider specialty may not bill this service.
243 (11/01/15)	Services not authorized by network/primary care providers.	0226	BILL PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
243 (11/01/15)	Services not authorized by network/primary care providers.	0229	SERVICE PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO.OR MORE	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0191	REVIEW RA MESSAGE PAGE FOR EXPLANATION	N206 (11/01/15)	The supporting documentation does not match the information sent on the claim.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0338	HYSTERECTOMY PROC REQ REVIEW OF HYST RECEIPT OF INFO FORM	N175 (11/01/15)	Missing review organization approval.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0366	MISSING/INVALID STERILIZATION TIME REASON	N463 (11/01/15)	Missing support data for claim.



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250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0505	LTC CENSUS DATA MISSING FOR SERVICE MONTH AND YEAR	M127 (11/01/15)	Missing patient medical record for this service.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0641	RX FROM PHYSICIAN REQUIRED	N667 (11/01/15)	Missing prescription.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0874	ADJ/VOID AND MATCHING HISTORY CLAIM MUST BOTH BE MEDIA 7	N221 (11/01/15)	Missing Admitting History and Physical report.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0889	GA MATCHING HISTORY NOT FOUND	N221 (11/01/15)	Missing Admitting History and Physical report.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0909	REQUIRES MATCHING EPSDT CLAIM FOR PAYMENT	N683 (11/01/15)	Missing/Incomplete/Invalid prior treatment documentation.



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250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0940	CLAIM REQUIRES REVIEW - MEDICARE PART A ATTACHMENT	M124 (11/01/15)	Missing indication of whether the patient owns the equipment that requires the part or supply.
250 (01/29/16)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0957	CLAIM CORRECTED OR REPROCESSED BY REQUEST	N26 (01/29/16)	Missing itemized bill/statement.
250 (11/01/15)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	1604	NO FQHC DELIVERY, OB/GYN OR ENCOUNTER MATCHING CLAIM	N206 (11/01/15)	The supporting documentation does not match the information sent on the claim.
250 (11/01/19)	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	1685	NO FQHC GROUP COUNSELING MATCHING CLAIM	N206 (11/01/19)	The supporting documentation does not match the information sent on the claim.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0092	INV/MISS EPSDT IMMUNIZATION STATUS CODE(S)	N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.



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251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0093	INV/MISS EPSDT SCREENING INFORMATION INDICATORS	N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0094	INV/MISS OR CONFLICTING EPSDT PHYSICAL DATA INDICATOR	N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0095	INV/MISS EPSDT RACE CODE	N78 (11/01/15)	The necessary components of the child and teen checkup (EPSDT) were not completed.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0096	EPSDT ANTICIPATORY GUIDANCE MISSING OR INVALID	N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0097	INVALID EPSDT PHYSICAL SCREEN INDICATOR	N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0098	INVALID OR MISSING EPSDT CONTINUED CARE	N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.



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251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0099	EPSDT WIC INDICATOR INVALID OR MISSING	N78 (10/16/03)	The necessary components of the child and teen checkup (EPSDT) were not completed.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0105	FOR TPL/HMO CLAIMS HAVING AN ATTACHMENT CODE 15	N446 (11/01/15)	Incomplete/invalid document for actual cost or paid amount.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0251	PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS	N657 (11/01/15)	This should be billed with the appropriate code for these services.
251 (01/01/16)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0318	MED NEEDY SPENDDOWN RECIP- ATTACHMENT REVIEW	N225 (01/01/16)	Incomplete/invalid documentation/orders/notes/summary/report/chart.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0460	INSURANCE ATTACHMENT INVALID/MISSING	N245 (11/01/15)	Incomplete/invalid plan information for other insurance.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0598	INVALID LEVEL-OF-CARE CODE	M135 (11/01/15)	Missing/incomplete/invalid plan of treatment.



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251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0640	INVOICE/PRICE LIST ATTACHED IS INVALID/INSUFFICIENT	N354 (11/01/15)	Incomplete/invalid invoice.
251 (11/01/15)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0650	MISSING PENNSYLVANNIA HOSPITAL FISCAL YEAR DATA	N570 (11/01/15)	Missing/incomplete/invalid credentialing data.
251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0838	PROVIDER-PRODUCED EOB INCOMPLETE	N705 (05/01/16)	Incomplete/invalid documentation.
251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0839	ADJUSTMENT MUST HAVE CORRECTED CLAIM WITH ATTACHMENTS	N255 (01/01/14)	Missing/incomplete/invalid billing provider taxonomy.
251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0848	ADJUST CLM MISSING PAYER/CARRIER CODE AND/OR TPL PAYMENT	N245 (11/01/15)	Incomplete/invalid plan information for other insurance.
251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0948	EOB MISSING FOR CARRIER/PAYOR REPORTED ON CLAIM	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.



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251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0971	MISSING CARRIER CODE/PAYOR ID	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
251 (01/01/14)	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0974	TPL PAYMENT AMOUNT FROM EOB MISSING ON CLAIM	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0019	INVALID INTERNAL CONTROL NUMBER (ICN)	M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0245	ATTACHMENT REQUIRED OR INCORRECT ATTACHMENT FOR PROCEDURES	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0261	OPERATIVE/ANES. , HISTORY AND/OR PATH REPORT REQUESTED.	N214 (11/01/15)	Missing/incomplete/invalid history of the related initial surgical procedure(s).
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0264	SPECIAL PROGRAM CODE - REVIEW ATTACHMENT	N175 (11/01/15)	Missing review organization approval.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0320	MED NEEDY SPENDDOWN - INVALID/MISSING ATTACHMENT	M58 (04/01/18)	Missing/incomplete/invalid claim information. Resubmit claim after corrections.



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252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0349	SEC OPINION FORM INCOMPLETE,MISSING DATA OR IS OUT OF DATE	N706 (11/01/15)	Missing documentation.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0352	INSUFFICIENT MEDICAL DOCUMENTATION FOR STERILIZATION	N706 (11/01/15)	Missing documentation.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0353	ATTACHED FORM DATA INCORRECT/MISSING/ILLEGIBLE	N28 (11/01/15)	Consent form requirements not fulfilled.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0355	STERILIZATION FORM REQUIRED	N706 (11/01/15)	Missing documentation.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0386	KID-CARE UNABLE TO DETERMINE COVERAGE	N375 (11/01/15)	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0464	HIPAA CLAIM DENIED NO ATTACHMENT SUBMITTED	N706 (11/01/15)	Missing documentation.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0669	DETAILED DESCRIPTION NEEDED FOR PROCEDURE CODE BILLED	N350 (11/01/15)	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.



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252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0847	INCORRECT ICN ON FD-999	M47 (08/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
252 (01/01/14)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0965	MEDICARE INPATIENT PART A EOB MISSING	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
252 (01/01/14)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0966	MEDICARE INPATIENT PART B EOB MISSING	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
252 (01/01/14)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0967	MEDICARE PHYSICIAN PART B EOB MISSING	N4 (01/01/14)	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0995	NO MATCHING HISTORY CLAIM FOR CREDIT RECORD	M47 (11/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
252 (11/01/15)	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	0997	IMAGINERY CLAIM - REVIEW REQUIRED	M47 (11/01/15)	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
256 (11/01/15)	Service not payable per managed care contract.	1327	HMO RESPONSIBLE FOR NON-ABP FACILITY COSTS	N95 (07/01/09)	This provider type/provider specialty may not bill this service.
256 (11/01/15)	Service not payable per managed care contract.	1338	ESRD BILLABLE SERVICE	N95 (11/01/15)	This provider type/provider specialty may not bill this service.
256 (11/01/15)	Service not payable per managed care contract.	1381	ACTIVE MANAGED CARE FOUND W/O ACTIVE ELIGIBILITY	N52 (11/01/15)	Patient not enrolled in the billing provider's managed care plan on the date of service.



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258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	0506	RECIPIENT INELIGIBLE TO RECEIVE LTC SERVICES	N30 (01/01/14)	Patient ineligible for this service.
258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	1313	INVALID CLAIM TYPE FOR DEPT OF CORRECTIONS	N193 (11/01/15)	Alert: Specific federal/state/local program may cover this service through another payer.
258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	1316	CLAIMS FOR DEPARTMENT CORRECTIONS INMATE	N103 (11/01/15)	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.
258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	1318	DOC RECIPIENT INELIG ON DATE OF SERVICE	N30 (10/01/08)	Patient ineligible for this service.
258 (11/01/15)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	1319	DOC RECIPIENT NOT ON FILE	N30 (10/01/08)	Patient ineligible for this service.
258 (01/29/16)	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	2290	PHARMACY CLAIM NOT PAYABLE FOR SPC 98 OR 99	N30 (11/10/14)	Patient ineligible for this service.
261 (01/29/16)	The procedure or service is inconsistent with the patient's history.	0887	POS/MATCHING HISTORY NOT FOUND		
267 (11/01/15)	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	0908	UNABLE TO PRICE MULTIPLE SURGERY CLAIM	N61 (11/01/15)	Rebill services on separate claims.
269 (11/01/15)	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0268	ANESTHESIA UNITS NOT ON PROCEDURE FILE FOR DATES OF SERVICE	N130 (11/01/15)	Consult plan benefit documents/guidelines for information about restrictions for this service.
269 (11/01/15)	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1629	DENTAL ANESTHESIA CLAIM CUTBACK BY BEHAVIOR MANAGEMNT CLAIMS	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.



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272 (01/01/21)	Coverage/program guidelines were not met.	1703	POSTPARTUM VISIT EXCEEDS 6 MONTHS FROM L&D	N357 (01/01/21)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
275 (06/13/13)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	0960	CLAIM UPDATED WITH PATIENT PAYMENT		
275 (06/13/16)	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	0961	SYSTEM UPDATE TO PATIENT INCOME		
A1 (10/16/03)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.	0539	THIS LIVERY SVC IS ONLY VALID IN COUNTIES 07, 09 AND 90	N59 (10/16/03)	Alert: Please refer to your provider manual for additional program and provider information.
A1 (10/16/03)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.	0942	CLAIM VOIDED DUE TO POST-PAYMENT REVIEW BY MUNICIPALITY.	N35 (10/16/03)	Program integrity/utilization review decision.
A1 (02/13/12)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.	1363	CANNOT CHANGE A DOCUMENT LEVEL SURGERY	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
A1 (11/15/11)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.	1364	CANNOT ADJUST A LINE LEVEL SURGERY	N381 (08/01/15)	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.
A1 (12/01/22)	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Use this code only when a more specific Claim Adjustment Reason Code is not available.	1860	CLAIMSXTEN: PROCEDURE TO DIAGNOSIS COVERAGE	N569 (12/01/22)	Not covered when performed for the reported diagnosis.



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A8 (11/01/15)	Ungroupable DRG.	0480	GROUPER ASSIGNED A NEW DRG CODE	N657 (11/01/15)	This should be billed with the appropriate code for these services.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	0242	SPECIAL PROGRAM/PROGRAM STATUS CODE-PROCEDURE RESTRICTION	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	0244	INVALID PROGRAM STATUS FOR SEMI PROCEDURES	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
B5 (01/01/14)	Coverage/program guidelines were not met or were exceeded.	0626	PAYMENT REDUCED TO MAC MAXIMUM	N14 (10/16/03)	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	0732	ADJUSTMENT TO DENTURES WITHIN 6 MONTHS OF DELIVERY	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	1008	CARRIER AMOUNT EXCEEDS MAXIMUM VALUE ALLOWED	N640 (11/01/15)	Exceeds number/frequency approved/allowed within time period.
B5 (11/01/15)	Coverage/program guidelines were not met or were exceeded.	1202	PREMIUM SUPPORT PROGRAM - STATE REVIEW REQUIRED.	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
B5 (01/27/21)	Coverage/program guidelines were not met or were exceeded.	1468	PROC CODE RESTRICT FOR NON-ADDP RECIEP(PSC NOT EQUAL TO 780)	N115 (01/27/21)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
B5 (07/01/23)	Coverage/program guidelines were not met or were exceeded.	1472	SPECIAL PROGRAM CODE RESTRICTION FOR SERVICE DATE(S)	N115 (07/01/23)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.



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B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0201	SERVICING PROVIDER NOT ELIGIBLE ON DATE(S) OF SERVICE	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0299	SERVICE PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0387	BILLING PROVIDER NOT ENROLLED IN CLIA	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
B7 (01/01/14)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0388	BILLING PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE	N570 (01/01/14)	Missing/incomplete/invalid credentialing data.
B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0389	BILLING PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE	N570 (11/01/15)	Missing/incomplete/invalid credentialing data.
B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0436	SUBMITTER NOT ELIGIBLE FOR CLAIM TYPE ON ACTIVITY DATE	N115 (11/01/15)	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
B7 (01/03/16)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0440	LTC PHARMACY INELIGIBLE FOR UD RECYCLING.		



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B7 (10/16/03)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0593	CAPITATION CATEGORY RATE NOT IN EFFECT FOR DATE OF SERVICE	N65 (10/16/03)	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
B7 (01/29/16)	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2295	FACILITY PROVIDER IS NOT ACTIVE ON THE DATE OF SERVICE		
B10 (01/01/14)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	0751	PAYMENT REDUCED - SURGERY/VISIT LIMITATION	M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
B10 (01/01/14)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	0905	MULTIPLE SURGERY-REDUCED BY INCIDENTAL PROCEDURE	M144 (01/01/14)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
B10 (10/16/03)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	0976	MEDICAID PAYMENT REDUCED BY OTHER INSURANCE	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B10 (10/16/03)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	0987	DEDUCT AMT INCLUDES MEDICARE OR PRIVATE INS REFUND TO STATE	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
B10 (11/01/15)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	1612	PARTIAL PATIENT PAYMENT AMOUNT APPLIED	M144 (11/01/15)	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2192	UNNECESSARY QUANTITY REDUCTION		
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2242	BENEFIT STAGE 50, NOT PART D-PART B DRUG PAID UNDER PART C		
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2243	BENEFIT STAGE 60 - NOT PART D - SUPPLEMENTAL BENEFIT		



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B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2244	BNFT STG 70-NOT PARTD CLM-PD BY NEGOTIATED PRICE-PARTD DRUG		
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2245	BNFT STG 80-NOT PARTD CLM-PD BY NGTIATED PRC-NOT PARTD DRUG		
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2246	BNFT STG 60/62/80/90 NOT ON FORMULARY EXCEPTION		
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2274	BNFT STG 61-NOT PARTD CLM-PD BY COADMIN PLAN BNFT-PARTD DRUG		
B10 (01/29/16)	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	2275	BNFT STG 62-NOT PARTD CLM-PD BY COADMIN PLAN-NOT PARTD DRUG		
B11 (01/29/16)	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	0894	OVERRIDE FOR EDIT 893		
B11 (01/01/16)	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	2039	EXEMPT LTC RECIPIENTS FROM MEDICARE PART CO-PAYMENT		
B12 (11/01/15)	Services not documented in patient's medical records.	0991	STATE APPROVED PAYMENT	N199 (11/01/15)	Additional payment/recoupment approved based on payer-initiated review/audit.
B12 (01/29/16)	Services not documented in patient's medical records.	2189	HMS-INITIATED FAIR HEARING OVERRIDE		
B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0324	HMO COVERED SERVICE - PAYMENT NOT JUSTIFIED BY ATTACHMENT	N347 (11/01/15)	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0475	HISTORY RECORD ALREADY ADJUSTED OR VOIDED	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0742	PREVIOUS EXTRACTED TOOTH	M86 (10/16/03)	Service denied because payment already made for same/similar procedure within set time frame.



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B13 (11/01/15)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0749	ANESTHESIA SERVICE ALREADY PAID FOR SAME DATE OF SERVICE	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0826	DUPLICATE OF PREVIOUSLY PAID CLAIM - DENIED AFTER REVIEW	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0876	CO-PAY FOR SERVICE DATE PAID - SEE CONFLICTING ICN ON RA	N347 (11/01/15)	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0888	CLAIM VOIDED DUE TO STATE AUDIT - SEE REMITTANCE MESSAGE 624	N35 (10/16/03)	Program integrity/utilization review decision.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0914	ROUTINE PROCE CARRIED OUT IN NICU ARE INCL IN GLOBAL FEE	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0915	MULTIPLE LTC/HOSPICE CLAIMS PROCESSED SAME MONTH AND YEAR	M86 (11/01/15)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0921	SEVERE DRUG/DRUG INTERACTION - NO PA OVERRIDE CAPABILITY	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0922	DRUG INDICATES PREGNANCY PRECAUTION WARNING	MA80 (10/16/03)	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0931	OVERLAPPING DATES OF SERVICE FOR PROCEDURE CODE GROUP	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/16/03)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0935	GENERAL INPATIENT CARE & INPATIENT CLAIM BILLED SAME DAY	M86 (08/31/04)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1656	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NJ	M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1657	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PA	M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
B13 (10/01/14)	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1658	DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NY	M86 (10/01/14)	Service denied because payment already made for same/similar procedure within set time frame.
B15 (10/16/03)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0547	UNIT DOSE PAYABLE FOR NURSING HOME RECIPIENT ONLY	M15 (10/16/03)	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.



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B15 (01/01/14)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0723	LAB PANEL PROCEDURE CODE NOT ON FILE	M51 (01/01/14)	Missing/incomplete/invalid procedure code(s).
B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1463	PENDING DOULA INCENTIVE PAYMENT FOR REPROCESS	N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.
B15 (03/01/20)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1682	TELEDENTISTRY CODE REQUIRES RELATED SERVICE CODE	N357 (03/01/20)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
B15 (01/01/19)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1686	SUD MGMT CLAIM WITH NO MATCHING E&M CLAIM	N357 (01/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
B15 (12/01/19)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1687	GROUP CLINICAL VISIT CLAIM WITH NO MATCHING E&M CLAIM	N357 (12/01/19)	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
B15 (01/01/21)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1704	DOULA INCENTIVE PAYMENT MISSING REQUIRED CLAIMS	N674 (01/01/21)	Not covered unless a pre-requisite procedure/service has been provided.



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B15 (12/01/22)	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1855	CLAIMSXTEN ADD ON EDIT	N122 (12/01/22)	Add-on code cannot be billed by itself.
B18 (01/01/14)	This procedure code and modifier were invalid on the date of service.	0545	NDC NOT ON DRUG FILE	M119 (10/16/03)	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
B20 (11/01/15)	Procedure/service was partially or fully furnished by another provider.	0788	ADJUSTMENT DENIED/ORIG PAID CORRECTLY	N10 (11/01/15)	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
P14 (01/29/16)	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	2074	CLAIM HAS BEEN PREVIOUSLY VOIDED BY STATE - CANNOT RESUBMIT		
P21 (01/01/16)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	0845	ADJUSTMENT DENIED/ EOMB REQUIRED	N479 (01/01/16)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).



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P21 (01/29/16)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	0893	INSURANCE COVERAGE KNOWN, BILL TPL		
P21 (11/01/15)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	0993	CLAIM DENIED AT PROVIDER REQUEST	N55 (09/10/13)	Procedures for billing with group/referring/performing providers were not followed.
P21 (11/01/15)	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	1621	DENY REASON CODE OR DENY EXPLANATION MISSING ON EOB	N479 (11/01/15)	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).