APPENDIX B

Claim Status Code List

STATUS CODE	STATUS MESSAGE/DESCRIPTION
01	CLAIM REJECTED AT NEIC - REFER TO NEIC DAILY R022 ERROR REPORT
02	CLAIM REJECTED AT NEIC ENVOY-FAIRFAX
10	CLAIM SENT TO PAYER
11	CLAIM SENT TO PAYER
12	CLAIM SENT TO THIRD PARTY ORGANIZATION, NO FURTHER UPDATES TO FOLLOW
13	CLAIM SENT TO THIRD PARTY ORGANIZATION
14	CLAIM FORWARDED TO PAYER FROM THIRD PARTY ORGANIZATION
15	CLAIM RESENT TO PAYER BY NEIC AT PAYER'S REQUEST
16	CLAIM MAILED TO PAYER, NO FURTHER UPDATES TO FOLLOW
17	CLAIM SENT TO PAYER - FURTHER UPDATES ARE NOT AVAILABLE
19	PAYER RECEIVED CLAIM, RETURNED INVALID STATUS
1Z	NOT ASSIGNED - CLAIM SENT TO PAYER
	ALL-PAYER MESSAGES
A1	CLAIM REJECTED IN VALIDATION
A2	CLAIM REJECTED - CHECK R022 REPORT
A3	CLAIM SENT FOR ALL-PAYER ROUTING
A4	CLAIM SENT ON PAPER DUE TO PENDING ENROLLMENT
A5	CLAIM REJECTED DUE TO PENDING ENROLLMENT
A6	CLAIM MAILED TO PAYER, NO FURTHER UPDATES TO FOLLOW
A7	CLAIM SENT TO PAYER, NO FURTHER UPDATES TO FOLLOW
A8	CLAIM SENT TO PAYER
A9	PAYER ACKNOWLEDGES RECEIPT OF CLAIM, NO FURTHER UPDATES TO FOLLOW
A0	PAYER REJECTED CLAIM, NO FURTHER UPDATES TO FOLLOW
AA	CLAIM RECEIVED, PRINTED AND MAILED BY PRINT CENTER
AB	CLAIM RECEIVED AND MAILED WITH INCOMPLETE ADDRESS. IF UNDELIVERABLE IT WILL BE RETURNED TO YOU BY MAIL
AC	CLAIM FORWARDED TO PRINT CENTER
	RECEIVED MESSAGES
20	CARRIER ACKNOWLEDGES RECEIPT OF CLAIM
21	CARRIER ACKNOWLEDGES RECEIPT OF CLAIM, NO FURTHER UPDATES TO FOLLOW
211	CARRIER ACKNOWLEDGES RECEIPT OF CLAIM, NO FURTHER UPDATES TO FOLLOW
221	CARRIER ACKNOWLEDGES RECEIPT OF CLAIM, ALL FURTHER UPDATES WILL COME DIRECTLY FROM THE PAYER
2A	CLAIM RETURNED TO PROVIDER, NO FURTHER UPDATES TO FOLLOW
2B	CLAIM FORWARDED TO THIRD PARTY ADMINISTRATOR, NO FURTHER UPDATES TO FOLLOW
2C	CLAIM FORWARDED INDIVIDUAL HEALTH UNIT, NO FURTHER UPDATES TO FOLLOW

STATUS CODE	STATUS MESSAGE/DESCRIPTION
2D	CLAIM FORWARDED HMO/PPO, NO FURTHER UPDATES TO FOLLOW
2E	CLAIM FORWARDED HMO, NO FURTHER UPDATES TO FOLLOW
2F	CLAIM FORWARDED PPO, NO FURTHER UPDATES TO FOLLOW
2G	CLAIM RETURNED TO NEIC FOR 837 TRANSLATION CORRECTION
2H	CLAIM FORWARDED TO PPO FOR REPRICING
2I	CLAIM RECEIVED FROM PPO WITH REPRICING INFORMATION
2J	INITIAL ANALYSIS SHOWS ALL OR SOME OF THE SERVICES MAY BE CAPITATED
2K	INITIAL ANALYSIS SHOWS ALL OR SOME OF THE SERVICES MAY BE CAPITATED, NO FURTHER UPDATES TO FOLLOW
2L	CLAIM FORWARDED TO PRINCIPAL FINANCIAL GROUP.
2L1	CLAIM BELONGS TO COVENTRY HEALTH INS. RESUBMIT ELECTRONICALLY TO COVENTRY.
2M	CLAIM FORWARDED TO THE UNITEDHEALTHCARE SYSTEM, FURTHER UPDATES WILL FOLLOW FROM THAT SYSTEM.
2N	CLAIM RETURNED TO PROVIDER, LETTER TO FOLLOW
2P	CLAIM ACCEPTED BY CLEARINGHOUSE - NO FURTHER STATUS MESSAGES
2Q	CLAIM REJECTED BY CLEARINGHOUSE - SEE ERROR REPORT FOR DETAILS
2R	CLAIM ACCEPTED BY ENVOY-FAIRFAX, FORWARDED TO PAYER
2T	CLAIM FORWARDED TO THE METRAHEALTH - TRAVELERS SYSTEM, FURTHER UPDATES WILL FOLLOW FROM THAT SYSTEM.
2U	THIS CLAIM WAS REFERRED TO GHI'S MEDICAL CLAIM DEPT. FOR PROCESSING
2V	CLAIM REJECTED AT CLEARINGHOUSE FOR MISSING/INVALID RECORDS
2Z	NOT ASSIGNED - CARRIER ACKNOWLEDGES RECEIPT OF CLAIM
	PENDING MESSAGES
30	CLAIM IS PENDING AT RECEIVER SITE
31	CLAIM IS PENDING AT RECEIVER SITE, NO FURTHER UPDATES TO FOLLOW
3A	PENDING: COORDINATION OF BENEFITS (C.O.B)
3B	PENDING: CLAIM SENT TO EMPLOYER FOR CERTIFICATION
3C	PENDING: INTERNAL REVIEW/AUDIT
3D	PENDING: INTERNAL REVIEW/AUDIT - PARTIAL PAYMENT MADE
3E	PENDING: ADDITIONAL INFORMATION REQUESTED FROM INSURED
3F	PENDING: ADDITIONAL INFORMATION REQUESTED FROM PROVIDER
3G	PENDING: ELIGIBILITY REVIEW
3H	PENDING: DUPLICATE CLAIM
3I	PENDING: CLAIM LOADED FOR ONLINE PAYMENT REVIEW
3J	PENDING: CLAIM REFERRED TO ANALYST, NO FURTHER UPDATES TO FOLLOW
3K	PENDING: CLAIM ASSIGNED TO AN APPROVER
3L	PENDING: CLAIM WAITING FOR FINAL APPROVAL
3M	PENDING: ADDITIONAL INFORMATION REQUESTED
3N	PENDING: CLAIM BEING RESEARCHED FOR INSURED ID/GROUP NUMBER ERROR
3P	PENDING: CLAIM WAITING FOR INTERNAL PROVIDER VERIFICATION
3Q	PENDING: CLAIM REFERRED TO INTERNAL ACCOUNTING

STATUS CODE	STATUS MESSAGE/DESCRIPTION
3R	PENDING: CLAIM REQUIRES ADDITIONAL INFORMATION - LETTER TO FOLLOW
3S	PENDING: PRE-AUTHORIZATION REVIEW
3T	PENDING: STOP PAYMENT HAS BEEN REQUESTED
3U	PENDING: UNDERPAYMENT PENDED FOR FUTURE ADJUSTMENT
3V	PENDING: SECOND SURGICAL OPINION REVIEW
3W	PENDING: CLAIM HAS BEEN SPLIT BY CARRIER
3X	PENDING: PRIOR PEND OF RELATED CLAIM
3Y	PENDING: PRE-NATAL CHARGES ON HOLD UNTIL DELIVERY
3Z	PENDING: ORTHO LINE PENDED TO DETERMINE MONTHLY ALLOWANCE
PA	PENDING: ADDITIONAL INFORMATION REQUESTED FROM EMPLOYER
PB	PENDING: UNDER FINAL PROCESSING - NO ACTION REQUIRED AT THIS TIME
PC	PENDING: CLAIM IS BEING REPROCESSED - UPDATED MESSAGE TO FOLLOW
PD	PENDING: PLAN/BENEFIT REVIEW
PE	PENDING: REVIEW OF CHARGES
PF	PENDING: ADDITIONAL PROCESSING REQUIRED AT CARRIER SITE - NO FURTHER UPDATES TO FOLLOW
PG	PENDING: CLAIM IN PROCESS - NO ACTION REQUIRED AT THIS TIME
PH	PEND: MEDICAL REVIEW
PI	PEND: RESEARCHING ELIGIBILITY
PJ	PEND: RESEARCHING ELIGIBILITY FOR DOS
PK	PEND: CLAIMS RESEARCH
	COMPLETION MESSAGES
40	CLAIM ADJUDICATION PROCESS HAS BEEN COMPLETED BY CARRIER
4A	COMPLETED: NO COVERAGE FOR NEWBORNS
4B	COMPLETED: EXPENSES INCURRED PRIOR TO COVERAGE
4C	COMPLETED: EXPENSES INCURRED AFTER COVERAGE TERMINATED
4D	COMPLETED: NO DEPENDENT COVERAGE
4E	COMPLETED: DUPLICATE CLAIM
4F	COMPLETED: PRE-EXISTING CONDITION
4G	COMPLETED: PRE-CERTIFICATION PENALTY TAKEN
4H	COMPLETED: PAYMENT REFLECTS USUAL AND CUSTOMARY CHARGES
4I	COMPLETED: PAYMENT MADE ACCORDING TO PLAN PROVISIONS/BALANCE DUE FROM INSURED
4J	COMPLETED: PAYMENT MADE IN FULL
4K	COMPLETED: NO PAYMENT DUE TO PPO ARRANGEMENT: THIS AMOUNT IS NOT INSUREDS RESPONSIBILITY
4L	COMPLETED: ADDITIONAL INFORMATION REQUESTED FROM INSURED
4M	COMPLETED: ADDITIONAL INFORMATION REQUESTED FROM PROVIDER
4N	COMPLETED: PRE-TREATMENT REVIEW
4P	COMPLETED: PAYMENT MADE ACCORDING TO PLAN PROVISIONS
4Q	COMPLETED: PAYMENT HAS BEEN DENIED FOR THIS CLAIM

STATUS CODE	STATUS MESSAGE/DESCRIPTION
4R	COMPLETED: PAYMENT DENIED DUE TO ELIGIBILITY
4S	COMPLETED: NO PAYMENT WILL BE MADE FOR THIS CLAIM
4T	COMPLETED: FULL OR PARTIAL PAYMENT DENIED FOR THIS CLAIM
4U	COMPLETED: FULL OR PARTIAL CHARGES APPLIED TO DEDUCTIBLE
4V	COMPLETED: FULL OR PARTIAL PAYMENT MADE, ADDITIONAL INFORMATION REQUESTED FROM INSURED
4W	COMPLETED: PARTIAL OR COMPLETE DENIAL, C.O.B. CLAIM MAY BE RECONSIDERED AT A FUTURE DATE
4X	COMPLETED: PARTIAL OR COMPLETE DENIAL, MEDICAL NECESSITY NOT DOCUMENTED
4Y	COMPLETED: CLAIM WAS PROCESSED AS AN ADJUSTMENT TO A PREVIOUS CLAIM
4Z	COMPLETED: NEWBORN'S CHARGES PROCESSED ON MOTHER'S CLAIM
7A	COMPLETED: ADDITIONAL INFORMATION REQUESTED, CLAIM MAY BE RECONSIDERED AT A FUTURE DATE
7B	COMPLETED: CLAIM CONTAINS SPLIT PAYMENT
7C	COMPLETED: CLAIM COMBINED WITH OTHER CLAIMS(S)
7D	CLAIM PROCESSED ACCORDING TO PLAN PROVISIONS, RESULTING IN NO BENEFIT ISSUED - EOB WILL FOLLOW
7E	COVERAGE HAS LAPSED FOR THIS POLICY
7F	NO ADDITIONAL PAYMENT FOR DATA SUBMITTED
7G	ANSWER TO APPEAL ON COVERED CHARGES HAS BEEN SENT
7H	FULL OR PARTIAL PAYMENT DENIED, SERVICES NOT COVERED
7I	PAYMENT LIMITED BY PLAN PROVISIONS, EOB TO FOLLOW
7J	BRIDGE DECLINED, TOOTH EXTRACTED PRIOR TO COVERAGE
7K	WORK RELATED ILLNESS/INJURY NOT COVERED
7L	PERIODONTAL TREATMENT CHARGES WITHOUT PERIODONTAL POCKET CHARTING DENIED - CLAIM MAY BE RESUBMITTED
7M	FULL OR PARTIAL PAYMENT DENIED, FREQUENCY LIMITATION EXCEEDED FOR SERVICE(S) BILLED
7N	COVERED CHARGES LIMITED BY POLICY PROVISIONS
7P	PERIODONTAL MAINTENANCE WITHOUT DATES/DETAILS OF PRIOR TREATMENT DENIED - CLAIM MAY BE RESUBMITTED
7Q	COMPLETED: PARTIAL DENIAL
7R	THIS CLAIM WAS REFERRED TO THE MEDICAL CLAIM DEPARTMENT FOR PROCESSING.
CA	COMPLETED: COVERAGE FOR PROCEDURE NOT AVAILABLE UNTIL CLAIMANT INSURED FOR PERIOD SPECIFIED IN POLICY
CB	COMPLETED: PROCEDURE DENIED - COVERAGE NOT ELECTED IN 31 DAYS OF DATE INDIVIDUAL QUALIFIED
CC	COMPLETED: CLAIM SUBJECT TO C.O.B. CLAIM MAY BE RECONSIDERED ON RECEIPT OF PRIMARY CARRIER'S EOB
CD	COMPLETED: PROCESSED AS PPO CLAIM. ACTUAL CHECK AMOUNT MAY BE ADJUSTED DUE TO PPO UTILIZATION RESERVE
CE	COMPLETED: DEPENDENT NOT COVERED

STATUS CODE	STATUS MESSAGE/DESCRIPTION
CF	COMPLETED: CLAIMANT BEYOND COVERED AGE
CG	COMPLETED: MAXIMUM ANNUAL BENEFIT PAID
CH	COMPLETED: MAXIMUM LIFETIME BENEFIT PAID
CI	COMPLETED: PROCEDURE NOT COVERED UNDER POLICY
CJ	COMPLETED: PROCEDURE DID NOT MEET POLICY TERMS
CK	COMPLETED: PROCEDURE DENIED BECAUSE FREQUENCY LIMITATION WAS EXCEDED
CL	COMPLETED: ORTHODONTIC INSTALLMENT RELEASED - FUTURE INSTALLMENTS PENDING
CM	COMPLETED: CLAIM REROUTED TO PAYOR 87726 - TRAVELERS
CN	COMPLETED: CHARGE EXCEEDS REASONABLE AND CUSTOMARY CHARGE FOR THIS SERVICE
CP	COMPLETED: PAYMENT REFLECTS A REDUCTION DUE TO SERVICES PERFORMED BY AN OUT-OF-NETWORK PROVIDER
CDA	TREATMENT NOT DUE TO SICKNESS OR ACCIDENT
CDB	PROVIDER IS NOT RECOGNIZED UNDER THE CONTRACT
CDC	NURSING SERVICE NOT COVERED
CDD	MAJOR MEDICAL MAXIMUM FOR ONE CONDITION HAS BEEN REACHED
CDE	MEDICINE DOES NOT NEED A PRESCRIPTION
CDF	PURCHASE OF MEDICAL EQUIPMENT IS NOT COVERED
CDG	ONLY RENTAL OF MEDICAL EQUIPMENT IS ALLOWABLE
CDH	ONLY ORIGINAL COST OF ARTIFICIAL LIMB IS COVERED
CDI	ARTIFICIAL LIMB LOSS PRIOR TO EFFECTIVE DATE
CDJ	POLICY HAS DENTAL COVERAGE ONLY
CDK	MAXIMUM BENEFIT FOR COVERAGE HAS BEEN EXHAUSTED
CDL	CLAIM HAS BEEN FORWARDED TO PCS
CDM	ALLOWABLE FOOT SERVICE MAXIMUM HAS BEEN EXCEEDED
CDN	ALLOWABLE BACK SERVICE MAXIMUM HAS BEEN EXCEEDED
CDO	RADIAL KERATOTOMY IS NOT COVERED
CDP	EPO BENEFITS ARE NOT PAYABLE
CDQ	MAXIMUM DOLLAR AMOUNT PER VISIT FOR BACK TREATMENT EXCEEDED
CDR	CLAIM DENIED BECAUSE REQUESTED INFORMATION NOT RECEIVED
CDS	BENEFITS REDUCED BECAUSE PRIOR AUTHORIZATION NOT OBTAINED FOR NON-PPO PROVIDER
CDT	BENEFITS REDUCED BECAUSE PROGRAM NOT COMPLETED
CDU	ADJUDICATION COMPLETE: SEE EOB
	UNPROCESSED CLAIM MESSAGES
50	CLAIM REQUIRES SPECIAL HANDLING AT CARRIER SITE
501	HMO RESPONSIBILITY
502	PROCEDURE CODE INCONSISTENT WITH PATIENT'S AGE
503	PENALTY-ABSENCE OF PRE-CERTIFICATION
504	CLAIM DENIED/REDUCED-SERVICE IS NOT SUPPORTED
505	PROVIDER NOT CERTIFIED

STATUS CODE	STATUS MESSAGE/DESCRIPTION
506	DUPLICATE CLAIM/SERVICE
507	BENEFIT MAXIMUM REACHED
508	CLAIM DENIED-REQUESTED INFO NOT PROVIDED OR INCOMPLETE
509	CLAIM DENIED-INSURED HAS NO DEPENDENT COVERAGE
50A	PROVIDER SIGNATURE INDICATOR INVALID, M NOT ACCEPTED
50B	WORKERS COMP INDICATOR INVALID, U NOT ACCEPTED
50C	SERVICE END DATE MAY NOT CONTAIN ZEROS
50D	AN UNIDENTIFIED ERROR HAS BEEN DETECTED. YOU WILL BE NOTIFIED IF ANY ACTION IS REQUIRED TO RESUBMIT
50E	TYPE OF SERVICE INVALID IF B,C,D,G,I,P,R
50F	CLAIM EXCEEDS ALLOWED NUMBER OF DETAIL LINES FOR THIS PAYER (34)
50G	PAYER DOES NOT ACCEPT UNSPECIFIED PROCEDURE CODES
50H	SERVICE DATE IS REQUIRED BY THE PAYER FOR THIS PROCEDURE
50I	PLEASE SUBMIT THE PRIOR PLACEMENT DATE FOR THIS PROCEDURE
51	MISSING OR INVALID DATA PREVENTS CARRIER FROM PROCESSING THIS CLAIM
511	CHARGES EXCEED FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT
512	CLAIM DENIED/REDUCED-CHARGES PAID BY ANOTHER PAYER-COB
513	CLAIM CONTAINS DUPLICATE PROCEDURES ON THE SAME DAY
514	CLAIM SHOULD BE FORWARDED TO THE PPO NETWORK
51A	CLAIM INVESTIGATION REQUIRED. PAYOR CONTACT WILL FOLLOW
51B	CLAIM REJECTED BY CARRIER DUE TO UNTIMELY FILING
51C	SUBMIT PAPER CLAIM WITH ER REPORT
51D	PATIENT LAST NAME DOES NOT MATCH CARRIER FILES
51E	PATIENT FIRST NAME DOES NOT MATCH CARRIER FILES
51F	CLAIM LACKS THE NAME,STRENGTH OR DOSAGE OF THE DRUG FURNISHED
51G	INCOMPLETE/INVALID PROCEDURE CODING METHOD
51H	ANESTHESIA CLAIMS MUST BE SUBMITTED ON PAPER
52	THIS BAXTER GROUP CLAIM REQUIRES SPECIAL HANDLING AT CARRIER SITE
521	CLAIM FILING LIMIT EXCEEDED
522	MAXIMUM AMOUNT/UNITS/PROCEDURES EXCEEDED
523	CLAIM EXCEEDS ALLOWED NUMBER OF DETAIL LINES FOR THIS PAYER (36)
524	CLAIM MORE THAN 365 DAYS OLD. RESUBMIT PAPER WITH SUPPORTING DOCUMENTATION
525	PAYER, GROUP AND EMPLOYER FIELD DATA IS BLANK OR INVALID. AT LEAST ONE OF THESE FIELDS IS REQUIRED.
526	CCN REQUIRES CPT OR HCPC PROCEDURE CODES IN THE CORRECT 5-NUM(NNNNN) OR 5-ALPHA/NUM(ANNNN) FORMAT.
527	REJECTION-INVALID MODIFIERS
528	SERVICES NOT PROVIDED OR AUTHORIZED BY OUR PROVIDERS
529	PAYMENT INCLUDED IN ALLOWANCE FOR BASIC SERVICE
53	REFER THIS CLAIM TO THE MEDICAL CARRIER FOR PROCESSING.
531	CLAIM DENIED-MAY BE COVERED BY ANOTHER PAYER
532	REJECTED-OUT OF AREA

STATUS CODE	STATUS MESSAGE/DESCRIPTION
533	CO-PAYMENT AMOUNT
534	REJECTED-REFERRAL DATE ERROR
535	WORKER'S COMP LIABILITY
536	CHARGES REDUCED-MULTIPLE SURGERY/ANESTHESIA RULES
537	PROVIDER NOT ELIGIBLE TO PRESCRIBE SERVICE
538	REJECTION-INVALID UNITS/DAYS
539	REJECTION-MISSING CPT CODE/HCPC CODE
54	MEDICAID NEWBORN CLAIM DID NOT CONTAIN BIRTH NOTIFICATION FORM. SUBMIT ON PAPER WITH THIS FORM.
541	REJECTED-CLAIM PROCESSED MANUALLY
542	INVALID OR MISSING REVENUE CODE
543	INVALID PROCEDURE CODE FOR MEDICAID - PLEASE SUBMIT THE APPROPRIATE X CODE
544	ADJUSTMENTS MUST BE SUBMITTED WITH AN EXPLANATION
545	MEMBER ID, DATE OF BIRTH, & GENDER DO NOT MATCH INFORMATION ON CARRIER FILES
546	SPECIAL HANDLING BASED ON AFFILIATED NETWORK PROCESSING INSTRUCTIONS
547	CODES EDITED BASED ON CPT GUIDELINES
548	CERTIFICATION/AMBULATORY REVIEW INFORMATION ASSOCIATED WITH CLAIM
549	REJECT: ALL LINE ITEMS MUST HAVE THE SAME PLACE OF SERVICE
55	INVAFILES LID PATIENT SEX
551	REJECT: DATE OF SERVICE CANNOT BE A FUTURE DATE
552	REJECT: INVALID VENDOR NUMBER FOR RENDERING PROVIDER
553	REJECT: MEMBER WITH ANOTHER IPA
554	REJECT: NOT ENROLLED IN AN HMO
555	REJECT: UNABLE TO IDENTIFY AS MEMBER
556	REJECT: INVALID DIAGNOSIS CODE
557	REJECT: INVALID MODIFIER
558	REJECT: INVALID PLACE OF SERVICE
559	REJECT: INVALID PROCEDURE CODE
56	INVALID DATE OF SERVICE
561	ADMITTING PHYSICIAN IS REQUIRED FOR INPATIENT HOSPITAL CLAIM
562	LINE ITEM DATE OF SERVICE IS MISSING
563	MODIFIER IS MISSING
564	DME MODIFIER IS MISSING (NU,UE,RR,KR)
565	RENDERING PROVIDER IS MISSING ON MEDICAL CLAIM
566	ATTENDING PROVIDER NAME IS MISSING
567	ATTENDING PROVIDER NAME IS INVALID (NOT OTHER)
568	PLEASE SUBMIT BILL TO WORKER'S COMPENSATION CARRIER
569	DISCHARGE HOUR IS REQUIRED FOR CLAIMS INCLUDING OBSERVATION CHARGES
57	INVALID REFERRING PROVIDER
571	DISCHARGE STATUS IS MISSING
572	DUPLICATE DIAGNOSIS CODE RECEIVED

STATUS CODE	STATUS MESSAGE/DESCRIPTION
573	ADMITTING DIAGNOSIS IS MISSING
574	CANNOT IDENTIFY EMPLOYER GROUP ON CLAIM
575	CLAIM DOES NOT CONTAIN ENOUGH INFORMATION TO REPRICE
576	MISSING PROCEDURE CODE
577	MISSING BILLED CHARGES FOR PROCEDURE CODE
578	MISSING UNITS FOR PROCEDURE CODE
579	MISSING RENDERING PHYSICIAN/FACILITY NAME
58	INVALID PROCEDURE MODIFIER CODE
581	CONTACT THE PAYER FOR CLAIM PAYMENT STATUS
582	RESUBMIT CLAIM DIRECTLY TO PAYER
583	MISSING PATIENT'S NAME
584	MISSING OR INVALID DATES OF SERVICE
585	MISSING ANESTHESIA MINUTES
586	MISSING TAX ID NUMBER
587	MANUALLY RESEARCHING CLAIM
588	CLAIM REPRICED AND MAILED TO PAYER
589	CLAIM REPRICED AND ELECTRONICALLY ROUTED TO PAYER
59	PROVIDER IS NOT CONTRACTED
591	PAYER HAS PROCESSING LIMIT OF 30 LINES PER CLAIM
592	INVALID SUBSCRIBER FIRST NAME
593	INVALID SUBSCRIBER LAST NAME
594	INVALID RELEASE OF INFO INDICATOR
595	ASSIGNMENT OF BENEFITS = NO
596	INVALID MEMBER ADDRESS 1
597	INVALID MEMBER CITY
598	INVALID MEMBER STATE
599	INVALID LINE ITEM CHARGE
5A	CONTRACT HAS BEEN CANCELLED BY THE POLICYHOLDER
5A1	OTHER - PLEASE CONTACT REPRICING ORGANIZATION
5A2	ACCIDENT DATE IS REQUIRED
5A3	ANESTHESIA SPECIFIC MODIFIER IS REQUIRED
5A4	COVERED DAYS IS MISSING FROM MEDICARE CLAIM
5A5	NON-COVERED DATA IS MISSING FROM MEDICARE CLAIM
5A6	CO-INSURANCE DATA IS MISSING FROM MEDICARE CLAIM
5A7	LIFETIME RESERVE DATA IS MISSING FROM MEDICARE CLAIM
5A8	ADMISSION TIME MISSING
5A9	ADMISSION SOURCE IS MISSING
5B	SOCIAL SECURITY/EMPLOYEE NUMBER NOT FOUND ON CARRIER FILES
5B1	ADMISSION TYPE IS MISSING
5B2	MEMBER NAME, AND/OR DATE OF BIRTH, AND/OR GENDER DO NOT MATCH INFORMATION ON CARRIER FILES
5B3	SURGICAL PROCEDURE CODE NOT ON FILE
5B4	EXTERNAL CAUSE OF INJURY - CODE NOT ON FILE

STATUS CODE	STATUS MESSAGE/DESCRIPTION
5B5	ACCIDENT HOUR IS INVALID - FOR VALUE CODE 45, AMOUNT MUST BE 00-23 OR 99
5B6	MISSING OR INVALID ALPHA PREFIX
5B7	PAYER NAME INVALID FOR ALPHA PREFIX
5B8	MISSING PATIENT RELATIONSHIP TO INSURED
5B9	CLAIM REJECTED BY PAYER
5C	ACCOUNT/GROUP NUMBER NOT FOUND ON CARRIER FILES
5C1	INVALID DOB, 00 NOT ACCEPTED FOR MONTH OR DAY IF UNKNOWN
5C2	SEX MUST BE M OR F, U NOT ACCEPTED
5C3	INVALID NON-COVERED DAYS
5C4	NEONATAL DRG MUST HAVE CONDITION CODE OF 88-96
5C5	ADMIT DATE INVALID
5C6	REVENUE CODE REQUIRES A HCPC CODE
5C7	MULTIPLE SERVICE DATES NOT ACCEPTED
5C8	VALUE AMOUNT SHOULD NOT BE GREATER THAN 999999.99
5C9	UB CLAIM TRANSFERRED TO HCFA 1500 DUE TO CLINIC VISIT
5D	GROUP NAME NOT FOUND ON CARRIER FILES
5D1	REQUIRES PAPER SUBMISSION INCLUDING COPY OF THE MEDICARE REMIT
5D2	UNIT FIELD INVALID. UNIT FIELD MUST BE EQUAL TO OR GREATER THAN 001
5E	GROUP NAME AND GROUP NUMBER NOT FOUND ON CARRIER FILES
5F	AT THE CUSTOMER'S REQUEST WE ARE UNABLE TO RECEIVE THESE CLAIMS ELECTRONICALLY
5G	NO COVERAGE FOR THE TYPE OF CHARGES SUBMITTED
5H	INDIVIDUAL INSURANCE POLICY
5I	GROUP PROCESSES THEIR OWN CLAIMS
5J	HANDLED BY THIRD PARTY ADMINISTRATOR
5K	HMO CLAIM
5L	CLAIM SUBMITTED TO INCORRECT CARRIER
5M	COVERAGE HAS BEEN CANCELLED FOR THIS INSURED
5N	NO DEPENDENT COVERAGE
5P	CLAIM REQUIRES PRICING INFORMATION
5Q	CLAIM REQUIRES SIGNATURE-ON-FILE INDICATOR
5R	SPOUSE/DEPENDENT NOT ON CARRIER FILES
5S	INSURED NAME/ADDRESS DOES NOT MATCH CARRIER FILES FOR SSN/INSURED ID
5T	INSURED NAME, SSN/EMPLOYEE ID NUMBER, ACCOUNT/GROUP NUMBER, GROUP NAME NOT FOUND ON CARRIER
5U	CLAIM REJECTED BY CARRIER - DIAGNOSIS DOES NOT MATCH PATIENT SEX
5V	DUPLICATE OF A PREVIOUSLY PROCESSED CLAIM
5W	DATE OF FIRST SYMPTOM PRIOR TO COVERAGE EFFECTIVE DATE
5X	NO MEDICAL COVERAGE EFFECTIVE FOR DATE OF SERVICE
5Y	NO DENTAL COVERAGE EFFECTIVE FOR DATE OF SERVICE
5Z	INCOMING PROVIDER DATA INVALID OR MISSING - PLEASE CALL CARRIER FOR FURTHER INSTRUCTIONS ON THIS CLAIM
5Z1	INCOMING PROVIDER DATA MISSING - PROVIDER NAME

STATUS CODE	STATUS MESSAGE/DESCRIPTION
61	CARRIER UNABLE TO RECEIVE CLAIM - PROVIDER NOT APPROVED AS AN ELECTRONIC SUBMITTER
62	INCOMING PROVIDER DATA MISSING/INCORRECT - PROVIDER MEDICARE NUMBER
63	INCOMING PROVIDER DATA MISSING/INCORRECT - PATIENT MEDICARE HIC ID NUMBER
67	INCOMING PROVIDER DATA MISSING/INCORRECT - ADMITTING DIAGNOSIS CODE
68	INCOMING PROVIDER DATA MISSING/INCORRECT - ATTENDING PHYSICIAN UPIN NUMBER
69	INVALID PROCEDURE CODE MODIFIER
8A	MEDICARE IS PRIMARY - PLEASE SUBMIT CLAIM TO MEDICARE
8B	PROVIDER IS NOT CONTRACTED WITH FIRST CHOICE HEALTH NETWORK
8C	PROVIDER IS NOT CONTRACTED WITH SOUND HEALTH FOR THESE SERVICES
8D	INTERIM BILLS CANNOT BE PROCESSED. PLEASE RESUBMIT UPON DISCHARGE
8E	CONTRACT ALLOWS FOR PER CASE OR PER DIEM PRICING,NO ADDITION ALLOWANCE AVAILABLE
8F	CLAIM CLOSED AS INCOMPLETE DUE TO LACK OF INFORMATION
8G	CLAIM FORWARDED TO ANOTHER INSURANCE CARRIER
8H	DOLLAR AMOUNT ON CLAIM EXCEEDES SYSTEM CAPACITY OF CLAIM RECEIVER - PLEASE SEND HARDCOPY
8J	PATIENT NOT ON CARRIER FILES OR PATIENT BIRTH DATE INVALID
8K	INACTIVE SUBSCRIBER FOR CLAIM DATE OF SERVICE
8L	INACTIVE PATIENT FOR CLAIM DATE OF SERVICE
8M	GROUP NUMBER NOT ON CARRIER FILES
8N	INVALID PROVIDER NUMBER FOR THIS CARRIER
8P	PRIMARY DIAGNOSIS INVALID FOR THIS CARRIER
8Q	SECOND DIAGNOSIS INVALID FOR THIS CARRIER
8R	PRIOR AUTHORIZATION/EPISODE NUMBER MISSING OR INVALID
8S	THIRD DIAGNOSIS INVALID FOR THIS CARRIER
8T	FOURTH DIAGNOSIS INVALID FOR THIS CARRIER
8U	INVALID PROCEDURE CODE FOR THIS CARRIER
8V	FIFTH DIAGNOSIS INVALID FOR THIS CARRIER
8W	SERVICE LINE DATES SPAN MORE THAN ONE CALENDAR YEAR
8WA	CLAIM IS MORE THAN TWO YEARS OLD
8X	DME RECORD EXCEED SYSTEM CAPACITY OF CLAIM RECEIVER - PLEASE SEND HARDCOPY
8Y	CLAIM INDICATES LIFE/DISABILITY PLAN NUMBER - RESUBMIT TO MEDICAL CARRIER USING MEDICAL PLAN NUMBER
8Z	CLAIM RECEIVER IS UNABLE TO PROCESS THIS CLAIM ELECTRONICALLY
80	SERVICE DATES DO NOT FALL WITHIN GROUP EFFECTIVE DATES
81	SERVICE DATES DO NOT FALL WITHIN GROUP EFFECTIVE DATES FOR PPO
812	MEMBER FOUND, BUT DATE OF BIRTH (YEAR AND MONTH) DID NOT MATCH
813	PROVIDER'S AFFILIATION DOES NOT EXIST

STATUS CODE	STATUS MESSAGE/DESCRIPTION
814	NO VALID PROVIDER AFFILIATION
815	INPATIENT COVERED DAYS AND NON-COVERED DAYS DO NOT EQUAL DATE SPAN
816	OCCURRENCE CODE =74, HOWEVER NO NON-COVERED DAYS ON CLAIM
817	INVALID PATIENT STATUS
818	OCCURRENCE CODE OR DATES ARE MISSING OR INVALID
819	TOTAL FOR SERVICES DO NOT EQUAL TOTAL CHARGES
82	CLAIM FORWARDED TO TPO FOR REPRICING
821	NO PROVIDER FOUND FOR OUTPATIENT CLAIM
822	PROVIDER'S NAME DID NOT MATCH FOR OUTPATIENT CLAIM
823	CLAIM TYPE NOT FOUND
824	CREATE DATE IS SPACES ON THIS SERVICE LINE
825	SERVICE NUMBER IS SPACES ON THIS SERVICE LINE
826	LOCATION CODE IS SPACES ON THIS SERVICE LINE
827	SERVICE FROM DATE IS SPACES ON THIS SERVICE LINE
828	SERVICE TO DATE IS SPACES ON THIS SERVICE LINE
829	LOCATION CODE IS NOT VALID
83	NO ACTIVE COVERAGE EXISTS FOR THIS INSURED
831	QUANTITY IS SPACES ON THIS SERVICE LINE
832	CHARGE AMOUNT IS SPACES ON THIS SERVICE LINE
833	NO VALID AFFILIATIONS FOUND
834	MODIFIER 2 IS NOT VALID
835	OTHER INSURANCE INFORMATION FOUND
836	PROVIDER NOT ASSOCIATED WITH A GROUP - CONTACT PROVIDER RELATIONS
837	MEMBER DATE OF BIRTH IS PRIOR TO SERVICE FROM DATE
838	MODIFIER 1 IS NOT VALID
839	THIS SERVICE LINE IS CORRECT; OTHER SERVICE LINES REJECTED
84	CLAIM FORWARDED TO EMPLOYER FOR CERTIFICATION
841	PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S AGE
842	PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
843	CLAIM LACKS UPIN OR THE UPIN IS INVALID
844	INCOMPLETE/INVALID OTHER PROCEDURE CODE(S) AND/OR DATE(S)
845	DID NOT COMPLETE OR ENTER ACCURATELY AN APPROPRIATE HCPC MODIFIER
846	INCOMPLETE/INVALID INVESTIGATION DEVICE EXEMPTION NUMBER
847	INCOMPLETE/INVALID PRINCIPAL PROCEDURE CODE AND/OR DATE
848	INVALID/MISSING GROUP INFORMATION OR INCOMPLETE MEMBER INFORMATION
85	SOCIAL SECURITY/EMPLOYEE # NOT FOUND - PLEASE CHECK ID CARD, CONTACT CLAIM OFFICE WITH QUESTIONS
86	MISSING/INVALID PROVIDER ID PREVENTS CARRIER FROM PROCESSING CLAIM
87	INVALID INSURED'S SSN PREVENTS CARRIER FROM PROCESSING CLAIM
88	PLEASE SEND COMPLETE PROVIDER ADDRESS
89	SPELLING OF INSURED'S LAST NAME DOES NOT MATCH CARRIER FILE
U0	PLEASE RESUBMIT THIS CLAIM TO CONSOLIDATED GROUP CLAIMS - PAYER ID 04284

STATUS CODE	STATUS MESSAGE/DESCRIPTION
BA	CLAIM REQUIRES PRICING BY BEECH STREET PREFERRED CARE BEFORE IT MAY BE PROCESSED BY UNITEDHEALTHCARE
BB	TYPE OF BILL INVALID FOR CARRIER
BB1	COALITION FOR CARE PROVIDER - PLEASE BILL THROUGH COALITION FOR CARE
BC	DX CODE DOES NOT SPECIFY BIRTH WEIGHT
BD	CLAIM/ENCOUNTER REJECTED BEFORE ENTERING THE ADJUDICATION SYSTEM, SUSPECT DUPLICATE CLAIM
BE	PROVIDER TAX ID NUMBER NOT FOUND
BF	SUBSCRIBER/MEMBER ID NOT FOUND
BG	PEIA CLAIMS MUST BE SUBMITTED TO BCBS
BN	COMPLETED: PATIENT NOT COVERED BY THIS POLICY WHEN SERVICES WERE RENDERED. NO BENEFITS ARE PAYABLE.
D2	DUPLICATE CLAIM TO PREVIOUS SUBMISSION
DP	DUPLICATE CLAIM WITHIN THE SAME FILE
64	TPO REJECTED CLAIM BECAUSE PAYOR NAME IS MISSING
65	TPO REJECTED CLAIM BECAUSE CERTIFICATION INFORMATION IS MISSING
66	TPO REJECTED CLAIM BECAUSE CLAIM DOES NOT CONTAIN ENOUGH INFORMATION
661	CLAIM ACCEPTED BY PAYER BUT PROVIDER # NOT SUBMITTED IN THE DESIGNATED FIELD AS REQUIRED BY PAYER
662	PENALTY-ABSENCE OF PRE-CERTIFICATION
663	REJ-AHPO NOT RESP FOR POS/PPO CLAIM PAYMENT
664	CONTRACTUAL ADJUSTMENT
665	ASSISTANTS NOT COVERED IN THIS CASE
666	DIAGNOSIS INCONSISTENT WITH PROCEDURE
667	COVERDED CHARGES
	REQUESTS FOR ADDITIONAL INFORMATION - DENTAL
6A	PLEASE SEND PERIODONTAL CASE TYPE DIAGNOSIS AND RECENT POCKET DEPTH CHART
6B	PLEASE SEND PAST PERIO TREATMENT HISTORY (SURG OR NON-SURG)
6C	PLEASE SEND PROPOSED TREATMENT PLAN FOR NEXT 6 MONTHS
6D	PLEASE SEND STUDY MODELS, X-RAYS, AND/OR NARRATIVE
6E	PLEASE SEND DESCRIPTION OF SERVICE(S)
6F	PLEASE SEND BREAKDOWN OF FEES FOR EACH DENTAL SERVICE
6G	PLEASE SEND NARRATIVE WITH POCKET DEPTH CHART
6H	PLEASE INDICATE IF PROSTHESIS/CROWN IS INITIAL OR REPLACEMENT
6I	PLEASE SEND RECENT X-RAY OF TREATMENT AREA AND/OR NARRATIVE
6J	PLEASE SEND RECENT FM X-RAYS AND/OR NARRATIVE
6K	PLEASE SEND WORKING PERIAPICALS OF ROOT CANAL
6L	PLEASE SEND DATE CANAL(S) OPENED AND DATE COMPLETED

STATUS CODE	STATUS MESSAGE/DESCRIPTION
6M	PLEASE SEND DATE(S) OF SERVICE(S)
6N	PLEASE SEND DATE OF PRIOR REPLACEMENT/REASON FOR REPLACEMENT
6O	PLEASE SEND LIST OF ALL MISSING TEETH (UPPER AND LOWER)
6P	PLEASE SEND YOUR PLANS FOR REPLACEMENT OF REMAINING MISSING TEETH
6Q	PLEASE SEND IMPRESSION AND SEATING DATE
6R	PLEASE SEND AREA BY TOOTH NUMBER
6S	PLEASE SEND TOOTH SURFACE(S) INVOLVED
6T	PLEASE DESCRIBE WHY SERVICES ARE NECESSARY
6U	PLEASE SEND TOOTH NUMBERS, SURFACES, AND/OR QUADRANTS INVOLVED
6V	PLEASE SEND DENTAL X-RAYS FOR THIS SERVICE
6W	PLEASE SEND DENTAL RECORDS FOR THIS SERVICE
6X	PLEASE SEND DATE TEETH EXTRACTED
6Y	PLEASE SEND AREA OF MOUTH FOR ORAL SURGERY
6Z	PLEASE SEND COMPOSITION
9A	PLEASE SEND DATE INITIAL ORTHO APPLIANCE INSERTED
9B	PLEASE SEND ESTIMATED DURATION OF ORTHO TREATMENTS
9C	PLEASE SEND ADDITIONAL MEDICAL INFORMATION/OPERATIVE REPORTS
9D	PLEASE ORTHO LINE PENDED TO DETERMINE MONTHLY ALLOWANCE
	MISSING/INVALID INFORMATION
QA	MISSING/INVALID BILLING PROVIDER TAX ID
QA1	INVALID BILLED AMOUNT SUBMITTED ON CLAIM - ZERO DOLLARS NOT ACCEPTED
QA2	INVALID VACCINE BILL - IMMUNIZATION ADMINISTRATION BILLED WITHOUT IMMUNIZATION
QB	MISSING/INVALID MARITAL STATUS
QC	MISSING/INVALID PATIENT ADDRESS
QD	INVALID DISCHARGE STATUS FOR BILL TYPE
QE	INVALID E DIAGNOSIS CODE
QF	MISSING/INVALID RENDERING PROVIDER TAX ID
QG	INVALID BILLING PROVIDER ADDRESS
QH	MISSING/INVALID RENDERING PROVIDER ADDRESS
QI	PAYER CANNOT PROCESS SECONDARY CLAIMS ELECTRONICALLY
QJ	PAYER CANNOT PROCESS HOSPICE CLAIMS ELECTRONICALLY
QK	PAYER CANNOT PROCESS PARTIAL HOSPITALIZATION CLAIMS ELECTRONICALLY
QL	MISSING/INVALID PAY-TO-PROVIDER TAX ID
QM	MISSING/INVALID PAY-TO-PROVIDER ADDRESS
QN	MISSING/INVALID PATIENT FIRST NAME
QO	MISSING/INVALID STATEMENT FROM DATE
QP	MISSING/INVALID STATEMENT TO DATE
QQ	MISSING/INVALID ADMISSION DATE
QR	MISSING/INVALID DISCHARGE DATE
QS	MISSING/INVALID DISCHARGE HOUR

STATUS CODE	STATUS MESSAGE/DESCRIPTION
QT	MISSING/INVALID ADMISSION HOUR
QU	MUST SEPARATE MOTHER/NEWBORN CHARGES
QV	NON-COVERED SERVICE, PLEASE REMOVE/RESUBMIT
QW	MISSING/INVALID PROCEDURE CODE MODIFIER
QX	MISSING/INVALID BILLING PROVIDER ID
QY	OTHER DIAGNOSIS INVALID FOR THIS CARRIER
QZ	MISSING/INVALID PATIENT DISCHARGE STATUS CODE
Q1	MISSING/INVALID PATIENT AMOUNT PAID
Q2	MISSING/INVALID ESTIMATED PATIENT BALANCE DUE
Q3	MISSING/INVALID ADMIT TYPE CODE
Q4	MISSING/INVALID ADMIT SOURCE CODE
Q5	MISSING/INVALID PLACE OF SERVICE
Q6	MISSING/INVALID OCCURRENCE CODE(S)
Q7	MISSING/INVALID VALUE CODE(S)
Q8	MISSING/INVALID MEDICAL RECORD NUMBER
Q9	MISSING/INVALID DIAGNOSIS RELATED GROUP
9E	MISSING/INVALID FEE SCHEDULE
9F	MISSING/INVALID PRODUCT INFORMATION
9G	MISSING/INVALID NUMBER OF VISITS
9H	MISSING/INVALID NUMBER OF PROCEDURE
9I	PROVIDER NOT VALID AT DATE OF SERVICE
9J	INVALID DIAGNOSIS OR DIAGNOSIS REQUIRES 4TH OR 5TH DIGIT
	REQUESTS FOR ADDITIONAL INFORMATION
TA	PLEASE INDICATE IF BLOOD HAS BEEN OR WILL BE REPLACED
TB	PLEASE SEND ACCIDENT INFORMATION
TC	PLEASE SEND ALLOWABLE/PAID FROM PRIMARY COVERAGE
TD	PLEASE SEND DETAILED DESCRIPTION OF SERVICES PROVIDED
TE	PLEASE SEND DISCHARGE SUMMARY
TF	PLEASE SEND DRG CODE(S)
TG	PLEASE SEND EMERGENCY ROOM NOTES/REPORT
TH	PLEASE SEND ITEMIZED BILL
TI	PLEASE SEND LAB REPORT
TJ	PLEASE SEND MEDICAL NECESSITY FOR TREATMENT/SERVICE
TK	PLEASE SEND MRI REPORT
TL	PLEASE SEND NAME, ADDRESS, PROFESSIONAL STATUS OF PROVIDER
TM	PLEASE SEND NURSE'S NOTES
TN	PLEASE SEND OPERATIVE REPORT
TO	PLEASE SEND SIGNED CLAIM FORM
TP	PLEASE SEND SPECIFIC CPT4 CODES/BREAKOUT OF CHARGES
TQ	PLEASE SEND A MORE SPECIFIC DIAGNOSIS CODE FOR SERVICE

STATUS CODE	STATUS MESSAGE/DESCRIPTION
TR	PLEASE SEND SPECIFIC ICD9 CODES/BREAKOUT OF CHARGES
TS	PLEASE SEND SPECIFIC REVENUE CODES/BREAKOUT OF CHARGES
TT	PLEASE SEND TOTAL ANESTHESIA MINUTES
TU	PLEASE SEND TREATMENT PLAN/MD'S RX
TV	PLEASE SEND X-RAY REPORTS
TW	PLEASE SEND X-RAYS AND INTERPRETATION
TX	PLEASE SEND BREAKDOWN OF THIS CHARGE BY DATE OF SERVICE
TY	PLEASE SEND STATEMENT OF MEDICAL NECESSITY AND COPY OF PRESCRIPTION
TZ	PLEASE SEND COPY OF THE PRESCRIPTION FOR THIS TREATMENT
T0	PLEASE SEND NAME, ADDRESS, TAX ID NUMBER, AND PHONE NUMBER OF REFERRING PHYSICIAN
T1	PLEASE SEND PHYSICAL THERAPY NOTES
T2	PLEASE SEND PHYSICAL THERAPY NOTES WHICH INCLUDE THE TIME FOR EACH CHARGE
T3	PLEASE SEND PHYSICAL THERAPY TIME
T4	PLEASE SEND DATE, PLACE, AND DESCRIPTION OF THE ACCIDENT OR DIAGNOSIS
T5	PLEASE SEND FULL NAME, ADDRESS, AND PHONE NUMBER OF PERSON WHO RENDERED THIS SERVICE
T6	PLEASE CALL G.E. MEDICAL BENEFITS CENTER - ADDITIONAL INFORMATION REQUIRED
T7	PLEASE SEND MEDICARE WORKSHEET
T8	PLEASE SEND OTHER CARRIER COB/PAYMENT INFORMATION
T9	ADDITIONAL INFORMATION REQUESTED, PLEASE CONTACT CARRIER
U1	PLEASE SEND MEDICARE EFFECTIVE DATE
U2	PLEASE SEND DEPENDENT EMPLOYMENT STATUS
U3	PLEASE SEND STUDENT STATUS INFORMATION
U4	PLEASE SEND REASON FOR LATE HOSPITAL CHARGES
U5	PLEASE SEND ATTENDING PHYSICIAN STATEMENT, INCLUDING MEDICAL NECESSITY AND RATIONALE FOR THIS SERVICE
U6	PLEASE SEND RELATED CONFINEMENT BILL
U7	PLEASE SEND PATIENT'S MEDICAL RECORDS
U8	PLEASE SEND A COMPLETE DESCRIPTION OF MEDICAL SUPPLIES
U9	PLEASE INDICATE THE PLACE OF SERVICE
UA	PLEASE SEND PHYSICAL THERAPY REASON
UB	PLEASE SEND THE SUBLUXATION LOCATION
UC	PLEASE PROVIDE DATE OF LAST X-RAY
UD	PLEASE INDICATE IF THE PATIENT IS AN INSULIN DIABETIC
UE	PLEASE INDICATE DATE OF INITIAL TREATMENT FOR THIS CONDITION
UF	PLEASE SEND THE COMPLETE MEDICAL HISTORY
UG	PLEASE SEND THE OBESITY MEASUREMENTS
UH	PLEASE SEND CHIROPRACTIC TREATMENT PLAN
UI	PLEASE SEND PSYCHIATRIC TREATMENT PLAN
UJ	PLEASE INDICATE THE SEMI-PRIVATE ROOM AND BOARD RATE

STATUS CODE	STATUS MESSAGE/DESCRIPTION
UK	PLEASE SEND THE STATEMENT OF MEDICAL NECESSITY FOR AMBULANCE TRANSFER FROM FACILITY TO FACILITY
UL	PLEASE INDICATE THE BODY LOCATION FOR JOINT INJECTION
UM	PLEASE INDICATE THE NAME AND ADDRESS OF ATTENDING PHYSICIAN PRESCRIBING DME
UN	PLEASE INDICATE IF THE CONDITION IS EMPLOYMENT RELATED
UP	PLEASE INDICATE AMOUNT OF TIME FOR EACH PSYCHIATRIC SERVICE
UQ	PLEASE SEND THE PATHOLOGY NOTES
UR	PLEASE SEND STATEMENT OF MEDICAL NECESSITY FOR AMBULANCE SERVICES
US	PLEASE SEND TREATMENT PLAN FOR SPEECH PATHOLOGY
UT	PLEASE SEND LICENSE/CERTIFICATION NUMBER FOR PERSON PERFORMING SERVICES
UU	PLEASE INDICATE PURCHASE PRICE FOR THE RENTED EQUIPMENT
UV	PLEASE INDICATE THE REASON FOR LATE DISCHARGE
UW	PLEASE SEND DATE YOU FIRST CONSULTED PATIENT FOR THIS CONDITION
UX	PLEASE INDICATE IF WORKER'S COMPENSATION WILL COVER THESE CHARGES
UY	PLEASE SEND A DETAILED DESCRIPTION OF THE ORTHOTIC, INCLUDING MATERIALS USED IN IT'S CONSTRUCTION
UZ	PLEASE SEND OFFICE NOTES/MEDICAL REPORT FOR THESE SERVICES
V1	PLEASE SEND A DSM-III-R CODE FOR THESE SERVICES
V2	PLEASE SEND THE PRIMARY SURGEON'S NAME
V3	PLEASE INDICATE THE CONDITION REQUIRING THE PROCEDURE YOU PERFORMED
V4	PLEASE INDICATE THE NAME, ADDRESS, AND EFFECTIVE DATE OF THE CARRIER
V5	PLEASE SEND OFFICE NOTES/MEDICAL REPORT
V6	PLEASE SEND CONCEPTION DATE AND EXPECTED DATE OF DELIVERY
V7	PLEASE SEND COMPLETE DESCRIPTION OF MEDICAL EQUIPMENT
V8	PLEASE SEND PURCHASE PRICE OF DURABLE MEDICAL EQUIPMENT NEEDED AND TIME NEEDED
V9	PLEASE SEND COPY OF PHYSICIAN'S PRESCRIPTION OF PHYSICAL THERAPY AND DURATION OF TREATMENT
VA	PLEASE INDICATE IF BILL HAS BEEN PAID
VB	PLEASE SEND DOCUMENTATION THAT FACILITY IS STATE LICENSED AND MEDICARE APPROVED AS A SURGICAL FACILITY
VC	PLEASE INDICATE IF AN MD OR DO IS ON STAFF OF THIS FACILITY
VD	PLEASE SEND DOCUMENTATION THAT PROVIDER OF PHYSICAL THERAPY IS MEDICARE PART B APPROVED
VE	PLEASE SEND TOTAL ORTHODONTIC TREATMENT FEE, INITIAL APPLIANCE FEE, MONTHLY FEE, LENGTH OF TREATMENT
VF	PLEASE INDICATE IF TREATMENT IS FOR ORTHODONTIC PURPOSES
VG	PLEASE INDICATE IF ORTHODONTIC RECORDS ARE INCLUDED IN TREATMENT PLAN; IF SO, PROVIDE FEE BREAKDOWN
VH	PLEASE INDICATE QUADRANT(S) FOR SERVICES RENDERED
VI	PLEASE INDICATE IF APPLIANCE IS FOR UPPER OR LOWER ARCH, IF APPLIANCE IS FIXED OR REMOVABLE

STATUS CODE	STATUS MESSAGE/DESCRIPTION
VJ	PLEASE SEND NARRATIVE DESCRIPTION FOR EMERGENCY EXAM OR TREATMENT
VK	PLEASE SEND DATE(S) ROOT CANAL THERAPY PREVIOUSLY PERFORMED
VL	PLEASE SEND LAST DATE WORKED
VM	PLEASE INDICATE REASON FOR EXTRA DAY ACCOMMODATIONS
VN	PLEASE INDICATE TYPE OF ACCOMMODATIONS
VO	PLEASE SEND LENGTH OF LACERATION
VP	PLEASE SEND NUMBER, LOCATION, SIZE OF TUMORS
VQ	PLEASE INDICATE BASIS FOR DISABILITY CERTIFICATION
VR	PLEASE SEND NEXT OF KIN FORM
VS	PLEASE SEND DRUG STATEMENT
VT	PLEASE SEND HEALTH HISTORY FORM
VU	PLEASE INDICATE IF OTHER COVERAGE EXISTS
VV	PLEASE INDICATE RELATIONSHIP OF ILLNESS TO PREGNANCY
VW	PLEASE INDICATE IF A THIRD PARTY OR PARTIES, INCLUDING ANY INSURANCE CARRIER, WILL COVER THIS ACCIDENT
VZ	PLEASE SEND MEDICARE STATEMENT OF PAYMENT OR REJECTION
Y1	PLEASE SEND PRE-OPERATIVE PHOTOS
Y2	PLEASE SEND VISUAL THERAPY REPORT
Y3	PLEASE SEND NO FAULT QUESTIONNAIRE
Y4	PLEASE SEND OFFICE NOTES FOR THIS DATE OF SERVICE AND ALL SERVICES THREE MONTHS PRIOR TO THIS DATE
Y5	PLEASE SEND OFFICE NOTES FOR THIS DATE OF SERVICE AND ALL SERVICES UP TO SIX MONTHS PRIOR TO THIS DATE
Y6	PLEASE SEND OFFICE NOTES FOR THIS DATE OF SERVICE AND ALL SERVICES UP TO ONE YEAR PRIOR TO THIS DATE
Y7	PLEASE SEND OFFICE NOTES FOR THIS DATE OF SERVICE AND ALL SERVICES UP TO TWO YEARS PRIOR TO THIS DATE
Y8	PLEASE SEND THE PATIENT'S INITIAL HISTORY AND PROFILE
Y9	PLEASE SEND POST-OPERATIVE PHOTOS
YA	PLEASE SEND PRE-OPERATIVE AND POST-OPERATIVE PHOTOS

End of Transaction Specification