Message Code	Message Description
1	Duplicate claim/service
1	The procedure code/bill type is inconsistent with the place of service
3	Duplicate claim/service
4	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier
6	Payment is included in the allowance for another service/procedure
7	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate
8	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes
9	Contractual adjustment
10	Claim/service adjusted because of the finding of a Review Organization
11	The diagnosis is inconsistent with the procedure
12	Payment adjusted because this care may be covered by another payer per coordination of benefits
13	Our records indicate that this dependent is not an eligible dependent as defined
14	Lifetime benefit maximum has been reached
15	Non-covered charge(s)
15	Services not provided or authorized by designated (network/primary care) providers
16	Discount agreed to in Preferred Provider contract
17	Service is classified as cosmetic and therefore not payable
17	These are non-covered services because this is not deemed a `medical necessity' by the
18	These are non-covered services because this is a pre-existing condition
19	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
19	Benefit maximum {0} for this time period has been reached
20	Charges for outpatient services with this proximity to inpatient services are not covered
21	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
22	These services / diagnoses are not covered due to a plan or policy exclusion.
24	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
25	Patient/Insured health identification number and name do not match
25	Deductible Amount
26	Co-payment Amount
26	Payment adjusted because procedure/service was partially or fully furnished by another provider
27	This provider was not certified/eligible to be paid for this procedure/service on this date of service
27	Coinsurance Amount
28	Send directly to WellCare at P.O. Box 31373 Tampa, FL 33631-3373 attn - Claim
29	The procedure code/bill type is inconsistent with the place of service
30	Payment is included in the allowance for another service/procedure
31	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes
32	Contractual adjustment

33	Claim/service adjusted because of the finding of a Review Organization
34	The diagnosis is inconsistent with the procedure
35	These are non-covered services because this is not deemed a `medical necessity' by the
35	The time limit for filing has expired
36	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
36	The time limit for filing claim by member has expired
37	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
38	Payment adjusted because procedure/service was partially or fully furnished by another provider
39	Service not included in supplier contract
39	This provider was not certified/eligible to be paid for this procedure/service on this date of service
40	Send directly to WellCare at P.O. Box 31373 Tampa, FL 33631-3373 attn - Claim
41	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
42	Benefits adjusted. Plan procedures not followed
43	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan
44	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer
45	Newborn's services are covered in the mother's Allowance
46	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules
46	Services are included in the per diem payment
47	Service payment was reduced because multiple procedures were performed that day to the member
47	Payment has been reduced because multiple surgeries were performed on the same day
48	Payment for this service is included in the room and board/per diem rate
49	Billed prior to authorization
50	Billed past authorization
51	The time limit for filing has expired
52	Maximum number of authorization units previously paid
61	This line or portion of a line is denied because the date of service is before the {0} coverage is effective.
62	This line or portion of a line is denied because the {0} coverage is terminated.
66	This line or portion of a line is denied because the benefit plan is not effective.
67	This line or portion of a line is denied because the benefit plan is terminated.
76	This line or portion of a line is denied because the product is not effective.
77	This line or portion of a line is denied because the product is terminated.
86	This claim is a candidate for coordination of benefits, but payment information from the other insurer was not provided.
89	Claims of this type are administered by {0}{1}.
91	This line or portion of a line is denied because the supplier is not effective.
92	This line or portion of a line is denied because the supplier is terminated.
95	This line or portion of a line is denied because the rendering practitioner is not effective.
96	This line or portion of a line is denied because the rendering practitioner status is

97	This line or portion of a line is denied because the rendering practitioner status is
114	ServiceFrequencyLimit is exceeded.
124	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
127	These are non-covered services because this is a pre-existing condition
149	Lifetime benefit maximum {0} has been reached
152	Group run-out period is exceeded
157	This service has been denied by the authorized reviewer. Payment is the responsibility of the member
158	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
159	These are non-covered services because this is not deemed a `medical necessity' by the
160	Payment denied for absence of authorization or exceeds authorization units
165	Services denied due to open {0} case(s)
166	Service may be a duplicate submission
168	Payment for this service is included in the per diem rate.
172	Payment adjusted because this care may be covered by another payer per coordination of benefits
173	Discount agreed to in Preferred Provider contract
174	Payment reduced for absence of, or exceeded, pre-certification/authorization
176	Service Line was included in Ambulatory Surgical Center fee.
177	Payment for this service is included in the confinement rate.
178	No payment has been made on this service because primary insurer has paid in full with no remaining balance.
179	Payment was adjusted to {0}% due to multiple services performed on the same day.
180	Pricing was adjusted to {0}% due to Modifier Pricing rules.
184	The maximum rental fee has been reimbursed for this service.
188	Allowed amount limit {0} has been exceeded by {1}.
189	Allowed amount limit {0} has been reached.
190	Denied authorization penalty. Member is responsible.
191	Denied authorization penalty. Provider is responsible.
192	No reimbursement penalty. Provider is responsible.
193	Payment reduced for absence of, or exceeded, pre-certification/authorization
220	Lifetime benefit maximum {0} has been exceeded by {1}.
221	Benefit maximum {0} for this time period has been exceeded by {1}.
223	Grace period for this CDH plan expired.
225	CDH plan is not effective for service.
226	Member is not enrolled in CDH plan.
250	Out-patient service delivered during in-patient confinement.
270	Service is excluded from supplier contract
276	This line is denied per default benefit provision.
277	Service is denied according to fee method or fee method undetermined
278	No payment has been made on this service because there was no remaining balance from the primary insurer.
287	External allowed amount limit of {0} has already been met.
312	Member Account is not effective on the claim processing date.

316	Claim line denied due to outpatient grouper edits.
317	Claim line denied by external bundling/fraud detection system.
319	Services have been limited based on benefits available
326	Authorization is required for this service.
327	The entire claim is denied due to edit override rules.
328	The claim line is denied due to edit override rules.
332	Payment for this service is included in the lesser than rate agreement.
350	Other discount applied.
351	Invalid submitted ID prefix on the claim
352	Denied Claim for invalid member prefix on claim line {0}.
378	Service has been denied, no secondary payment has been considered.
388	External units limit of {0} was exceeded.
401	Claim has been denied because the provider has not been assigned benefits or accepted assignment of benefits.
431	Services are not covered under arrangement, for reconsideration please submit to other
432	Please submit to other party
488	External days limit of {0} was exceeded.
500	Benefits adjusted. Plan procedures not followed
501	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer
503	Newborn's services are covered in the mother's Allowance
504	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules
505	Payment has been reduced because multiple surgeries were performed on the same day
506	Payment for this service is included in the room and board/per diem rate
507	Billed prior to authorization
508	Billed past authorization
509	Services not authorized
510	This service has previously been processed for another provider
513	Tax ID discrepency
515	Not contracted for service
517	The time limit for filing has expired
518	Maximum number of authorization units previously paid
520	Member not eligible on date of service
521	This line or portion of a line is denied because the supplier location is not effective.
522	This line or portion of a line is denied because the supplier location is terminated.
522	Appeal over turned
523	Incorrect provider paid
524	Claim paid provider in error
525	Claim has been adjusted to retract the monies paid to you in error
530	This amount has been applied to your deductible.
531	This line or portion of a line is denied because the practitioner role is not effective.
532	This line or portion of a line is denied because the practitioner role is terminated.
535	Member responsibility threshold {0} has been reached
536	MIPS Adjustment Applied
537	MIPS Bonus Applied
600	Please submit to other party
650	Member requires authorization

651	Supplier requires authorization
652	The claim line is denied due to an invalid diagnosis or procedure code.
653	The claim line is denied due to invalid diagnosis or procedure codes on other claim lines.
700	Denied Member Responsibility
701	Denied Supplier Responsibility
701	Payment for this service is included in the Inpatient Rehabilitation Facility confinement
704	Claim line denied due to EasyGroup SNF errors
1000	Line denied for member not covered through discharge for {0}.
1010	Service is replaced by an alternate service per alternate benefit rules
1011	Service replaces submitted service per alternate benefit rules
1012	Service is replaced by an alternate service per alternate benefit manual override
1013	Service replaces submitted service per alternate benefit manual override
1020	Benefit waiting period was not met
1044	Quality adjustment factor applied.
1045	Claim line denied due to Physician pricer
1046	Reimbursement included within the bundled rate
1100	Allowed amount reduced based on prior rentals.
3010	Claim denied due to contiguous county rule.
3020	Claim denied for flagged provider.
3030	Claim denied for flagged account.
BC03	Provider timely filing has been exceeded. For use when the Host Plan has indicated on the SF (SF Message Code 1011) that the providers timely filing limit has been exceeded.
BC05	This claim is reviewed at the request of the Host Plan. (U604 SFMC)
BC14	SF submitted under incorrect prefix
BC15	This claim has not met processing requirements; contact the provider
BC16	The provider has been instructed to bill the correct plan.
BP01	There is a maximum benefit allowance for Cardiac Rehabiliation. The maximum benefit has been provided.
BP02	There is a maximum benefit allowance for Pulmonary Rehabiliation. The maximum benefit has been provided.
BP04	This amount has been applied to your coinsurance.
BP05	You are responsible for the copay amount.
BP06	2 Sets of Bitewings covered per Calendar Year
BP08	Your contract covers 1 set of bitewing x-rays per calendar year. Allowance up to this maximum has been provided.
BP11	These TMJ-related services are not covered due to a plan or policy exclusion
BP12	Orthodontic services not covered due to a plan or policy exclusion
BP13	Pediatric Vision Frames and Contact Lens Maximum
BP14	These autism services are not covered due to a plan or policy exclusion
BP15	Acupuncture is not covered due to a plan or policy exclusion
BP16	These biofeedback services are not covered due to a plan or policy exclusion
BP17	Travel expenses are not covered due to a plan or policy exclusion
BP18	Hearing aids and related services / supplies are not covered due to a plan or policy
BP19	These services are not covered when rendered by this provider type
BP20	These contraceptive services are not covered due to a plan or policy exclusion
BP21	These vision services are not covered due to a plan or policy exclusion
BP22	These infertility services are not covered due to a plan or policy exclusion

BP23	These obesity-related services are not covered due to a plan or policy exclusion
BP24	These dental services are not covered due to a plan or policy exclusion
BP25	These drugs are not covered when administered in an outpatient setting due to a plan or policy exclusion
BP26	These services related to sexual dysfunction are not covered due to a plan or policy
BP27	These services have been submitted to the preferred pharmacy program for
BP28	Cosmetic-related services are not covered due to a plan or policy exclusion
BP29	These implant-related services are not covered due to a plan or policy exclusion
BP30	Services considered temporary in nature are not covered due to a plan or policy
BP31	Not covered due to the timeframe since the initial service / placement
BP32	These services / diagnoses are not covered due to member's age per a plan or policy
BP33	These services / applications are not covered for the teeth specified due to a plan or policy exclusion
BP34	Dental C Services are not covered due to a plan or policy exclusion
BP35	These routine maternity services are not covered for dependents due to a plan or policy exclusion
BP37	Preventive services received from out-of-network providers are not covered for this
BP52	No Coverage when not by Designated Provider
BP55	These services/diagnoses related to sex transformations or change are not covered due to a plan or policy exclusion.
BP56	Chronic Care Management Frequency Limit Met-Member Responsible
BP57	Chronic Care Management Frequency Limit Met-Provider Responsible
BP58	The maximum benefit allowance for the number of home health aide and skilled nursing care visits has been met.
CII	CII - Claim has been invalidated
CLM01	Our records indicate your other insurance carrier has primary responsibility for payment of these services. If there is a balance after their payment, send us a copy of their Explanation of Benefits form and we will reprocess the services as secondary carrier.
CLM02	Our records indicate your Medicare carrier has primary responsibility for payment of these services. A claim should be submitted to your Medicare carrier for payment.
CLM03	A coordination of benefits questionnaire was sent to you requesting info about other health insurance coverage. Until the completed questionnaire is signed and returned, claims cannot be processed per your contract. If you have any questions, please call Coordination of Benefits at 800-462-2924.
CLM04	Subscriber not found. The subscriber's identification does not match a valid subscription number.
CLM05	Subscription not effective of date(s) of service.
CLM06	Claim denied as patient cannot be identified as our insured.
CLM07	According to our records, this member is not currently listed on your family coverage.
CLM08	This individual is not currently listed on your coverage. Please contact your employer to add the member to your coverage to avoid further claim denials.
CLM09	The procedure code is inconsistent with the patient's gender. For use when there are provider billing errors not identified by the Host Plan.
CLM10	The procedure code is inconsistent with the patient's age. For use only when there are provider billing errors not identified by the Host Plan.
CLM11	The diagnosis is inconsistent with the provider type. For use only when there are provider billing errors not identified by the Host Plan.

CLM12	The procedure code is inconsistent with the modifier used or a required modifier is missing. For use only when there are provider billing errors not identified by the Host
CLM13	The diagnosis is inconsistent with the patient's age. For use only when there are provider billing errors not identified by the Host Plan.
CLM14	The diagnosis is inconsistent with the patient's gender. For use when there are provider billing errors not identified by the Host Plan.
CLM15	The bill type submitted on the claim is not compatible with the patient billed status. For use only when there are provider billing errors not identified by the Host Plan.
CLM16	This amount is in excess of the allowable amount established for this service.
CLM17	Our records indicate you have other insurance which has primary liability for these services. Other carrier payment information was received, however it was not complete. Please submit your other carrier Explanation of Benefits and we will reconsider these
CLM18	Our records indicate your Medicare carrier has primary responsibility for payment of these services. Medicare payment information was received, however it was not complete. Please submit your Medicare Explanation of Benefits and we will reconsider these services for payment.
CLM19	Claim denied because this is a work-related injury and thus the liability of the Workers Compensation carrier.
CLM20	This is an adjustment due to subrogation.
CLM21	Your auto insurance provided benefits for these services.
CLM22	This policy does not have coverage for dental services.
CLM23	Procedure code is not in effect or is incomplete for the date of service. Please resubmit with a valid code for the date of service.
CLM24	Services related to attrition are not covered due to a plan or policy exclusion.
CLM25	These services are not related to the specific service disability
CLM26	You are Medicare eligible, this plan limits payments to an amount that supplements the benefits that would be payable by Medicare, regardless whether or not Medicare benefits are paid. Benefits have been reduced by the estimated amount Medicare would have paid. You are responsible for this amount.
CLM27	These charges are processed by another carrier/vendor. Please submit to the correct carrier/vendor for processing.
CXTASR	No benefits are provided for Surgical Assistant's fee for this procedure.
CXTCON	This service is not allowed within the concurrent care timeline of another service.
CXTDIS	Your responsibility has been reduced by this amount as a result of a provider agreement with 'Plan'.
CXTDUP	This service has previously been processed for another provider.
CXTFRQ	This service exceeds the allowed frequency.
CXTINC	This service is considered inclusive to another service
CXTNAS	No benefits are provided for Surgical Assistant's fee for this procedure.
CXTNEV	Corelink Verbiage: Benefits are not provided for medical services determined to be for the treatment of specific hospital-acquired conditions or preventable medical errors.
CXTOCO	This service is not allowed within the concurrent care timeline of another service.
CXTODS	This amount over the 'Plan' allowance is the subscriber's responsibility
CXTOFQ	This service exceeds the allowed frequency
CXTOIN	This service is considered inclusive to another service
CXTONV	Benefits are not provided for medical services determined to be for the treatment of specific hospital-acquired conditions or preventable medical errors.

CXTOPY	This service is not allowed in full when performed in conjunction with related services.
CXTOSP	CXT Out of Network Scope of Practice Denial
CXTPAY	This service is not allowed in full when performed in conjunction with related services.
CXTSPE	Payment is denied for these services when performed/billed by this type of provider.
DNCB	Dental Non- Covered Service- Member Liable
EXCTC	Telephone / internet consultations are not covered due to a plan or policy exclusion
EXNPL	Not covered Service Par Provider Liable
EXNS- Nutri	Food and food products, including formula, are not covered due to a plan or policy
EXTMJ-Osseo	Implants related to TMJ are not covered due to a plan or policy exclusion
HST0001	Expenses incurred prior to coverage
HST0006	Dependent not eligible per contract age limit
HST0009	Patient not enrolled at time of service
HST0010	Expenses incurred after coverage termination
HST0012	Payment adjusted because coverage/program guidelines were not met or were
HST0033	Care was deemed not medically necessary
HST0037	Anesthesia service rendered by the surgeon is not covered per the subscriber's contract
HST0039	Procedure does not warrant the services of an anesthesiologist per the subscriber's
HST0051	Per the member's contract, multiple physicians and/or assistants are not covered in this
HST0053	Original claim processed incorrectly
HST0055	Services by an immediate relative or member of the same household are not covered
HST0067	Payment adjusted because charges have been paid by another carrier
HST0085	We have requested other coverage information regarding the patient. Our file has been closed and services denied.
HST0106	Charges are eligible for processing via existing crossover arrangements.
HST0188	No benefits payable when services are related to Worker's Compensation.
HST0189	Duplicate claim/service
HST0205	Services for diagnosis reported are not a benefit
HST0213	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
HST0230	The timely filing limit as outlined in the member's contract/benefit has expired.
HST0243	Benefit maximum for this time period has been reached per the member's benefit plan or policy.
HST0249	Maximum number of days has been allowed.
HST0263	Services denied at the time authorization/precertification was requested.
HST0264	Medical visits on the day of surgery are not covered.
HST0278	Maternity payable only for subscriber or spouse.
HST0291	Benefit maximum has been reached.
HST0347	Payment is being adjusted when performed/billed by this type of provider, by this type of provider in this type facility, or by a provider of this specialty.
HST0425	Non-covered charge(s).
HST0531	These are non-covered services because this is a pre-existing condition.
HST0561	Investigative procedure not a benefit.
HST0706	No record of membership.
HST0712	No dependent coverage.
HST0756	Patient has dental coverage only.
HST0851	The procedure is not covered because the patient's contract contains a specific exclusion for the condition/services reported.

HST0894	Benefits are not provided for services obtained from non-participating providers per the member's benefit plan or policy.
HST0947	The service is not covered because the charges do not meet qualifications for emergency/urgent care.
HST0969	These charges are not payable because the contract does not cover these services during the waiting period specified in the patient's contract.
HST0992	Rental charge exceeds purchase price of the durable medical equipment or cost for purchase has been paid on a prior claim.
HST1006	The service is not covered because the service was not provided by and/or ordered by the primary care physician or medical group.
HST1027	Our records indicate this dependant is not an eligible dependant as defined.
HST1029	Blue Shield coverage only.
HST1033	Blue Cross coverage only.
HST1036	Inpatient Blue Cross coverage only.
HST1038	The date of death precedes the date of service.
HST1052	Yearly benefit maximum has been reached.
HST1053	Reimbursement for this service is considered to be a portion of another service that has been allowed. Therefore, no payment can be made for this service.
HST1054	Payment for this procedure is included in our payment for other services performed on the same day by the same provider.
HST1056	The date of birth follows the date of service.
HST1065	Policyholder's premiums not paid to date.
HST1067	Payment has been denied because Medicare did not cover the charges on the claim.
HST1068	The charges have been reduced or denied because the member's benefit plan or policy are limited to semiprivate room.
HST1069	Provider contracts with both the Home and Host Plans. Close out claim and Host Plan should instruct provider to bill Home Plan directly.
HST1071	Duplicate service line.
HST1072	Member's primary care physician missing/invalid.
HST1074	Services not provided or authorized by designated (network) provider.
HST1075	Payment adjusted because this procedure/service is not paid separately.
HST1076	Not a benefit under this line of business. Reimbursement to the subscriber will be considered under another line of business.
HST1077	This is an Erisa account. Application of state mandate is optional.
HST1079	Another insurance carrier handles these services. Please handle directly with other
HST1082	Claim denied because this injury/illness is the liability of the no-fault carrier.
HST1083	SF submitted under incorrect prefix.
HST1084	Claim submitted under Inter-Plan Business traditional processing; claim should be submitted under BlueCard POS program.
HST1086	Claim part of global fee pricing arrangement. Payment has been made on claim with SF message code U700.
HST1087	Handle direct. Do not send paper claim. Home Plan will make payment from SF received.
HST1090	High dollar claim - reviewed and approved.
HST1095	Charges for outpatient services with this proximity to inpatient services are not allowed.
HST1096	Not covered unless the provider accepts assignment.
HST1097	Payment denied because service/procedure was provided as a result of war.

HST1098	The service is denied or payment reduced because transportation is covered only to the closest facility that can provide necessary care per the member's benefit plan or policy.
HST1100	Claim/service denied. Appeal procedures not followed or time limits not met.
HST1101	Contracted funding agreement - subscriber is employed by the provider of services.
HST1102	Non-covered service because member prior hospitalization or 30-day transfer requirement not met.
HST1103	Claim/service not covered/reduced because alternative services were available and should have been used.
HST1104	Services not covered because patient is enrolled in a hospice.
HST1105	The service is not covered because the service is not documented in patient's medical
HST1106	Payment adjusted because new patient qualifications were not met.
HST1109	Intermediary arrangement in place. File claim with intermediary.
HST1110	This claim/service is a duplicate of a claim that has been processed and paid to the member directly.
HST1111	This claim/service is a duplicate of a claim that has been processed and paid to the provider directly.
HST1112	This is a Medicare Advantage Type claim. Medicare charge limitations may apply.
HST1113	The payment on this claim includes a PSA (personal savings account) amount that is being made on behalf of the member.
HST1114	Benefits reduced because a National Specialty Center provider was not utilized for the procedure performed.
HST1115	Benefits not available because a National Specialty Center provider was not utilized for the procedure performed.
HST1116	Certificate or letter of medical necessity needed before a final benefit determination can be made.
HST1117	Emergency services records needed before a final benefit determination can be made.
HST1118	Accident date and/or onset date needed before a final benefit determination can be
HST1119	Progress notes/report needed before a final benefit determination can be made.
HST1120	Student certification information needed/need full-time student status information before a final benefit determination can be made.
HST1121	Completed subrogation/workers compensation questionnaire needed from member before a final benefit determination can be made.
HST1122	Discharge summary needed before a final benefit determination can be made.
HST1123	Medicare payment information needed before a final benefit determination can be
HST1124	Other carrier payment information needed before a final benefit determination can be
HST1125	Laboratory report needed before claim can be processed.
HST1126	Operative/surgical report needed before a final benefit determination can be made.
HST1127	Pathology report needed before a final benefit determination can be made.
HST1128	Claim Payment was reduced because required pre-certification/pre-authorization is not
HST1129	Radiology report needed before a final benefit determination can be made.
HST1130	Treatment plan needed before a final benefit determination can be made.
HST1133	The claim has been paid using a price negotiated directly with a non-par provider.
HST1141	Benefits for these services cannot be determined at this time. When records for this group have been properly reconciled, these services will be reconsidered for payment
HST1142	These services are not covered because they were provided in an inpatient setting which was determined to be not medically necessary. These charges are the member's

HST1143	These charges are not covered. Treatment, services or supplies that do not meet our guidelines are not covered under the member's plan.
HST1144	Your dental contract does not cover charges for treatment, services or supplies that do not meet our criteria for medical necessity or are not normally provided for the treatment of this condition.
HST1145	Incidental appendectomies performed without evidence of related illness or injury is not covered.
HST1146	These charges are not covered. As a result of arbitration, these services are the responsibility of the member's automobile insurance carrier.
HST1148	Our records indicate this patient has no other health coverage; however this claim was received with another carrier's payment information. These charges will be processed when the other carrier information is verified by the member.
HST1149	Based upon the indication that these services are work related, this claim has been
HST1150	These charges are not covered because the patient has exceeded the number of visits authorized.
HST1151	These maternity charges may not be payable as the member's maximum benefit has been reached.
HST1152	These charges are not eligible because they exceed the maximum number of units
HST1153	These charges are not covered. The services exceed the maximum number of visits allowed per the member's benefit plan or policy.
HST1154	This service has been paid as an exception to this patient's contract. This exception applies to this claim only.
HST1155	These charges cannot be processed because a detailed description of the service is missing or invalid. This information is needed to determine benefits per the member's benefit plan or policy. These charges will be considered when the requested information
HST1156	These charges cannot be processed until we receive the hospital charges, that relate to the professional fee. These charges will be considered when the requested information is
HST1157	Final benefit determination cannot be made until we receive health history information from the member.
HST1158	Final benefit determination cannot be made until we receive medical history information requested from another provider.
HST1159	These charges cannot be processed until we receive additional information requested from you. Your patient has not signed the authorization you require to release the information. These charges will be considered when the completed form and necessary medical records are received.
HST1160	These charges cannot be processed because a referral from the patient's primary care provider has not been received. These charges will be considered if a referral is
HST1161	The maximum benefit for services relating to a preexisting condition has been met.
HST1162	These charges for maternity care are not payable because the patient was not continuously covered by the contract from the date of conception through the
HST1163	These charges are not covered. Based upon the information submitted this service is
HST1164	These charges are not covered. A surgical room is not covered for this type of surgery performed.
HST1165	These charges are not covered. Custodial care is excluded under the patient's benefit plan or policy.
HST1166	These charges are not covered. The primary care provider did not authorize the services and the condition treated did not meet urgent care guidelines.

HST1167	These charges are not covered. The patient's primary physician has not approved this out-of-area care.
HST1168	These charges are not covered because the patient's contract does not allow a second surgical opinion from this type of provider.
HST1169	The Medicare Part A deductible is not covered under this patient's plan.
HST1170	The Medicare Part B deductible is not covered under this patient's plan.
HST1172	This payment represents the global rate made to the transplant center as a part of the transplant payment allowance.
HST1173	This payment represents the global rate for this patient's organ or bone marrow
HST1174	Payment for these services has been previously made to the transplant center as part of the transplant payment allowance.
HST1175	These charges are not covered. Services rendered in connection with dental injury are
HST1176	This service could not be covered. The maximum amount allowed for the facility fee for this surgical procedure was paid on a previous claim.
HST1179	No benefits are payable for this service. The primary carrier has paid more than or up to 100% of the allowance.
HST1180	A description of the services rendered or an itemized listing of charges is needed before the claim can be considered.
HST1181	The charges shown on the claim do not match those on the EOMB. Resubmit the claim with the corrected charges or return additional claims information.
HST1182	This charge is not covered. Services related to experimental procedures are excluded under the patient's benefit plan or policy.
HST1183	Counseling services are excluded under the patient's benefit plan or policy.
HST1185	Routine vision is not covered under this contract. These charges are the member's responsibility.
HST1186	The line level date of service is invalid for the HCPCS/revenue code combination.
HST1189	Well-baby care is excluded under the patient's benefit plan or policy.
HST1190	This charge could not be covered; routine physicals are excluded under the patient's benefit plan or policy.
HST1191	Home health care is not covered under the patient's benefit plan or policy.
HST1192	Electroshock therapy services are not covered under the benefit plan or policy.
HST1193	Convenience items are excluded under the patient's benefit plan or policy.
HST1194	This type of dental service is excluded under the patient's benefit plan or policy.
HST1195	Fluoride treatment is not covered under the patient's benefit plan or policy.
HST1197	Charges submitted during a leave of absence from the hospital are not covered.
HST1198	Hearing examinations, tests, hearing aids, and related supplies are excluded under your benefit plan or policy.
HST1199	This charge could not be covered, since routine immunizations are excluded under your benefit plan or policy.
HST1200	Non-covered orthopedic supplies, shoes or routine foot care under base and major
HST1202	Acupuncture services are excluded under the patient's benefit plan or policy.
HST1203	Biofeedback is excluded under the benefit plan or policy.
HST1204	The procedure code submitted on this claim is no longer valid.
HST1205	We have received an EOMB from Medicare. However, we also require an EOB from the patient's other insurance carrier.
HST1206	A copy of the ambulance report is needed before the claim can be considered.
HST1207	A copy of the Anesthesia report is needed before the claim can be considered.

HST1208	We need the physician's office records, the patient's history and physician and/or plan of treatment.
HST1209	A copy of the current blood gases report is needed before the claim can be considered. RPRE-X113
HST1210	Information about the ordering or referring physician (name/address) is needed before the claim can be considered.
HST1211	A copy of the psychiatric evaluation, along with the length of session, is needed before claim can be considered.
HST1212	The name, dosage, quantity and related NDC number of this drug are needed before this claim can be considered.
HST1213	Height, weight, and frame of the patient are needed before the claim can be considered.
HST1214	We do not have a valid name and date of birth for this newborn.
HST1215	A copy of the manufacturer's description of this supply/equipment is needed before the claim can be considered.
HST1216	A copy of the sleep study report is needed before the claim can be considered.
HST1217	A copy of the vein study report is needed before the claim can be processed.
HST1218	A copy of the delivery report is needed before the claim can be processed.
HST1219	A separate charge for venipuncture/arterial puncture is not covered.
HST1220	Only the professional component qualifies for reimbursement for this procedure.
HST1221	Coverage of this item is only considered when the item is purchased.
HST1222	This service is primarily educational and therefore excluded under the patient's benefit plan or policy.
HST1223	Artificial conception and/or in-vitro fertilization services are excluded under the member's benefit plan or policy.
HST1225	These charges are not covered. The services exceed the maximum number of visits allowed for home health care per the member's benefit play or policy.
HST1226	These charges are not covered. The maximum number of surgical procedures in a single surgical session has been exceeded, according to the member's benefit plan or policy.
HST1227	Coverage under the patient's benefit plan or policy is limited to one medical visit per day for the same condition.
HST1228	This claim has default paid at 100% allowable.
HST1229	The original claim default paid at 100% allowable.
HST1230	Charges for partial upper or lower dentures are not covered when the same provider has already billed for complete upper or lower dentures.
HST1231	These charges are not covered. The maximum number of lesion surgical procedures in a single surgical session has been exceeded.
HST1232	These charges are not covered because the dates on the treatment plan do not match the date(s) of service on this claim. These charges are member's responsibility.
HST1233	Services performed utilizing interactive audio and video telecommunication systems are not covered under the patient's benefit plan or policy.
HST1234	These charges are not covered. This anesthesia service is covered when the provider has received the appropriate certification. According to our records, you have not received this certification.
HST1235	Modifier TF identifies this as an intermediate level of care which is not listed as a covered service.

HST1236	These charges are not covered. This procedure is one that can only be received once in a patient's lifetime per the member's benefit plan or policy. Our records show that we have already processed a claim for this type of procedure for this patient.
HST1237	Newborn hearing tests are only covered under the member's benefit plan or policy when services are rendered by the hospital.
HST1238	Speech therapy is covered under this benefit plan or policy for correction of a speech impairment due to disease, surgery, injury, or congenital anatomical anomaly. Based on the information submitted, this service does not meet this criteria; therefore, this charge cannot be covered.
HST1239	This service is denied because the waiting period for transplant services has not been
HST1240	We need the first consultation date about this condition.
HST1241	Maternity benefits not available for the dependent.
HST1242	Home health care services are excluded under your benefit plan or policy when the services are received from a non-contracting home health care agency.
HST1243	Services received in a non-contracting skilled nursing facility are not covered under the patient's benefit plan or policy.
HST1244	This service could not be covered because it is related to a maternity or pregnancy condition. Your benefit plan or policy excludes coverage for maternity or pregnancy
HST1245	Routine well baby care not covered on an inpatient basis.
HST1246	This service could not be covered. The patient is not within the age limit for well child benefits under your benefit plan or policy.
HST1247	Private duty nursing services are not covered for this place of treatment.
HST1248	Claim was automatically crossed over to the member's Personal Savings Account. The provider may be receiving payment for the claim from a 3rd party. These charges are the member's responsibility.
HST1249	The claim has been paid using a price negotiated directly with the Blue Distinction Centers for Transplants (BDCT).
HST1250	Diagnosis or surgical procedure code is not in effect or is incomplete for the Date of Service. Please resubmit with a valid HIPAA Compliant Code for the Date of Service.
HST1251	Per group benefits, as secondary insurer, our liability under this contract is zero.
HST1252	Claim payment was reduced because an authorization was approved for an observation stay only.
HST1253	These charges are not covered. The services exceed the maximum number of units allowed per the member's benefit plan or policy.
HST1254	Claim Payment was reduced because it exceeds the maximum number of days
HST1255	We are the member's tertiary insurance carrier. Please submit claim to member's primary and secondary coverage carriers. Once claims processed by other carriers please submit claim with both primary and secondary EOB's to your Local Plan.
HST1256	The payment on this claim includes a PSA (personal savings account) amount that is being made on behalf of the member for claims that are normally non-covered under the members healthcare benefits.
HST1258	Member is Held Harmless for the amount above the maximum allowance.
HST1259	Coverage of this item is only considered when the item is purchased.
HST1260	Coverage of this item is only considered when the item is rented.
HST1261	Procedure/treatment has not been deemed 'proven to be effective' by the payer.
HST1263	The procedure code is inconsistent with the provider type/specialty
HST1264	The related or qualifying claim/service was not identified on this claim.

HST1265	Rental/purchase guidelines were not met.
HST1266	Payer deems the information submitted does not support this length of service.
HST1267	The referring provider is not eligible to refer the service billed.
HST1268	The prescribing/ordering provider is not eligible to prescribe/order the service billed
HST1269	The rendering provider is not eligible to perform the service billed.
HST1271	This provider was not certified/ eligible to be paid for this procedure/service on this date of service.
HST1272	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
HST1273	Penalty for failure to obtain second surgical opinion
HST1274	Final benefit determination cannot be made until we receive medical records that were previously requested on a related claim. No additional information is needed from you at this time.
HST1275	Final benefit determination cannot be made until we receive a tooth number.
HST1276	Maximum visits for Physical therapy have been reached. To request additional visits, we need the referring physician's prescription, initial evaluation, and treatment plan and progress notes from start of care thru last visit.
HST1277	Maximum visits for Speech therapy have been reached. To request additional visits, we need the referring physician's prescription, initial evaluation, and treatment plan and progress notes from start of care thru last visit.
HST1278	Final benefit determination cannot be made until we receive complete medical records.
HST1279	Final benefit determination cannot be made until we receive x-rays/photos.
HST1280	Final benefit determination cannot be made until we receive the entire psychiatric record with the exception of psychotherapy notes.
HST1281	Final benefit determination cannot be made until we receive the psychiatric assessment/evaluation.
HST1282	Final benefit determination cannot be made until we receive the results of psychiatric
HST1283	Final benefit determination cannot be made until we receive the psychiatric progress notes or psychiatric team conference notes.
HST1284	Final benefit determination cannot be made until we receive the substance abuse record with the exception of substance abuse therapy notes.
HST1285	Final benefit determination cannot be made until we receive specific requested medical information.
HST1286	This claim is a duplicate to a Medicare Crossover Claim.
HST1287	This claim is rejected due to an invalid diagnosis code.
HST1288	This claim reviewed at the request of the Host Plan.
HST1289	Medical Records have been requested from a local provider.
HST1290	Claim needs to be filed to the Plan in whose service area the specimen was drawn.
HST1291	Claim needs to be filed to the Plan in whose service area the DME equipment was shipped to or purchased at a retail store.
HST1292	Specialty Pharmacy Claim needs to be filed to the Plan in whose service area the ordering physician is located.
HST1294	Medicare-like Rate Applied.
HST1295	The ICD code version submitted by the provider is not compliant with Federal Regulation for the service/discharge date reported on this claim. If the provider participates, the Host Plan must ensure that the member is held harmless.
HST1296	Claim file closed until predetermination obtained by provider.

HST1297	Services denied at the time pre-authorization/pre-certification was requested.
HST1298	Claim denied because required pre-authorization is not on file.
HST1299	These charges are not covered. Services are subject to prior approval under the member's benefit plan or policy.
HST1300	The services submitted exceed the number of visits previously approved.
HST1301	These charges are not covered. Pre-authorization is required per the member's benefit plan or policy.
HST1302	Per member's benefit plan or policy, services were denied because an authorization was approved for an observation stay only.
HST1303	These charges are not eligible because they exceed the maximum number of days
HST1305	A copy of all diagnostic reports for the patient is needed before the claim can be
HST1306	A copy of the PET/MRI/CT scan report/results is needed before the claim can be
HST1307	A copy of the EEG report with analysis is needed before the claim can be considered.
HST1308	Provider timely filing has been exceeded.
HST1309	Care coordination Fees are not payable.
HST1310	Payment denied because service/procedure was provided outside the US.
HST1311	The procedure code/bill type is inconsistent with the place of service.
HST1312	The procedure code is inconsistent with the patient's gender
HST1313	The diagnosis is inconsistent with the procedure.
HST1314	The procedure code is inconsistent with the patient's age.
HST1315	The diagnosis is inconsistent with the provider type.
HST1316	The procedure code is inconsistent with the modifier used or a required modifier is
HST1317	The diagnosis is inconsistent with the patient's age.
HST1318	The diagnosis is inconsistent with the patient's gender.
HST1319	The bill type submitted on the claim is not compatible with the patient billed status.
HST1324	The local provider is required to enroll in the Medicaid Program where the member
HST1325	Required Medicaid Encounter Data Elements Missing
HST1327	DME Purchase reduced by prior rentals, member is held harmless.
MP01	Preauthorization is required for this procedure. Our records indicate that preauthorization was not obtained, therefore, this service is not covered
MP02	Preauthorization is required for this procedure. Our records indicate that preauthorization was not obtained, therefore, this service is not covered
MP06	No benefits are provided for services determined not medically appropriate and necessary. This amount is not your responsibility
MP07	No benefits are provided for services determined not medically appropriate and
MP08	No benefits have been provided because the information received from the health care provider did not substantiate or document the service billed. This amount is not your responsibility
MP09	No benefits have been provided because the information received from the health care provider did not substantiate or document the service billed
MP10	Service Requires approved prior authorization -Member Liable
MP11	This service is included in the payment made for a related procedure. This amount is not your responsibility.
MP12	This service is included in the payment made for a related procedure.
MP13	Your coverage does not provide benefits for infertility treatment and related services. This amount is your responsibiity
MP14	No benefits are provided for services primarily for obesity

MP15	Your coverage does not provide benefits for non-accident related temporomandibular joint services.
MP16	No benefits are provided for the treatment of myofascial pain. These Services are a coverage exclusion
MP17	No benefits are provided for any treatment or related complications leading to or in connection with sex transormations or change.
MP18	No benefits are provided for any treatment related to sexual dysfunction
MP19	Benefits for ambulance services are not available if soley for the convenience of the covered person, family or provider or if a less intensive level of transportation is
MP20	Benefits for conditions that existed prior to our coverage effective date are available only after your waiting period has been completed.
MP21	The maximum benefit for services relating to a pre-existing condition has been met.
MP22	Benefits for maternity conditions that existed prior to the members' effective date are available only after your waiting period has been completed.
MP23	No benefits are provided for anesthesia billed by the operating physician or assistant. This amount is not your responsibility.
MP24	Separate benefits are not paid for anesthesia when provided by the operating physician. Please refer to seciton 5(b) in your Blue Cross and Blue Shield Service Benefit Plan brochure. You are responsible for these charges, except when another carrier has paid
MP25	Your coverage does not cover treatment of removal of corns, callosities, or the cutting or trimming of nails.
MP26	No benefits are provided for these services. These services are a coverage exclusion.
MP27	Final determination cannot be made until we receive the physician's office records, the patient's history and physician's notes and/or plan of treatment.
MP28	Final benefit determination cannot be made until we receive health history information from the member.
MP29	No Benefits are provided when a health care provider bills servcies performed on self or own family members.
MP30	Maternity services not covered
MP31	No benefits are provided for servcies related to artificial insemination.
MP32	No benefits are provided for these services related to in-vitro fertilization.
MP33	There is a maximum benefit allowance for cardiac rehabilitation sessions. Benefits up to that maxium have been provided.
MP34	No benefits are provided for these health education services.
MP35	No benefits are provided for eye exams, refraction, glasses, contact lenses, eye exercisesor visual training.
MP36	No benefits are provided for travel, emals or lodging expenses.
MP37	No benefits are provided for sterilization reversals.
MP38	Pulmonary rehabilitation servcies are not covered for this diagnosis.
MP39	There is a visit maximum per condition for pulmonary rehabilitation. Benefits up to that maximum have been provided.
MP40	No benefits are provided for concurrent routine medical and surgical care. This amount is not your responsibility
MP41	No benefits are provided for this therapy service.
MP42	No benefits are provided for Surgical Assistant's fee for this procedure.
MP43	No benefits are provided for Surgical Assistant's fee for this procedure. This amount is not your responsibility

MP44	There is a maximum benefit allowance for the number of skilled nursing days. Benefits up to that maximum have been provided.
MP45	There is a maximum benefit allowance for the number of skilled nursing days. Benefits up to that maximum have been provided.
MP46	No benefits are provided for services related to elective abortions.
MP47	No benefits are provided for cosmetic services intended primarily to improve
MP48	There is a maximum benefit allowance for the number of skilled nursing facility days. Benefits up to that maximum have been provided.
MP49	No benefits are provided for hospitalizations primarily for convalescent or custodial care
MP50	No benefits are provided for rest home or custodial care medical services
MP51	Approval was not received for the level of services submitted.
MP52	Approval was not received for the level of services submitted.
MPEXM	No benefits are provided for services which are considered experimental or investigative.
MPEXPPL	No benefits are provided for services which are considered experimental or investigative. This amount is not your responsibility
PC01	This service is included in the payment made for a related procedure.
PC02	No benefits are provided for this service when provided by a chiropractor.
PC03	Services are not included in supplier contract.
PC04	This service is included in the payment made for a related procedure.
PC05	No benefits are provided for diabetic education when performed at a facility that is not certified by the American Diabetes Association.
PC06	Benefits are provided for rental costs for home medical equipment only up to the purchase price of the item.
PC07	Benefits are provided for rental costs for home medical equipment only up to the purchase price of the item.
PC08	This procedure code is an add-on code and must be billed with the primay procedure. A claim for the primary procedure has not been received. This amount is not your
PC09	Total Cost of Care Duplicate
PC10	These services are not covered when rendered by this provider type. This amount is not your responsibilty.
PRR	Purchase Reduce by Rental
PRRCY	Medicaid Saving Amount
PRRM	Purchase Reduce by Rental
RANNE	Please file the claim to the plan in whose service area the point of pick-up occurred
RDME	HME procedure requires 'RR' or 'NU' modifier
REMC	BCBSNE will not accept CPT codes 99241-99245 or 99251-99255. Please resubmit with a more appropriate E&M code
REMO	BCBSNE will not accept CPT codes 99241-99245 or 99251-99255. Please resubmit with a more appropriate E&M code
RHCR	HCPCS 'G0008' thru 'G0010' or '90471' thru '90474' must be with Revenue Code '045x', '0510', '0761' or '0771'
RIDC	Claim Frequency Type Code does not agree with Patient Status '30'
RINA	Facility Type Code and Claim Frequency Code combination '11x', '18x' or '21x' requires an accomodation charge
RLI	RLI - Claim has been returned
RMGO	Patient gender invalid
RMGU	Patient gender invalid

RPDXE	Primary diagnosis cannot be an External Cause of Injury code
RPREV	Non-prev dx code(s) invalid for preventative procedure code
RPSM	BCBSNE Rule 837P Modifier not valid for Procedure
RPTS	Modifier 26 and TC billed on same line is invalid
RRCZ	BCBSNE Rule: 837I - Charge greater than 0.00 is not allowed with revenue code
RRTT	Revenue Code '068x' requires Type of Admission equal to '5'
RVOC	Value Code '45' requires Occurr Code '01' thru"06|Value Code '45' requires Occurrence Code '01' thru '06'||4|16|N299|||||2|2
UM01	Precertification is required for this admission. Our records do not indicate that precertification was obtained; therefore, this admission is not covered.
UM02	Precertification is required for this admission. Our records do not indicate that precertification was obtained; therefore, this admission is not covered.
UM03	The allowable rate has been adjusted due to a readmission within 30 days
UMAML	UM Auth Member Liable
UMPC	UM MIDA Not Covered- Provider Liable
VRC201	Void due to Account Request
VRC202	Void due to Provider Audit
VRC203	Void due to Wrong Payee
VRC204	Void due to Retroactive cancellation
VRC205	Void due to Benefit Change/Correction
VRC206	Void due to Duplicate
VRC207	Void due to Lost/damaged check, stop payment on check
VRC208	Void due to Provider Audit
VRC209	Void due to Benefit Change/Correction
VRC210	Void due to Worker's Comp
VRC211	Void due to Medicare
VRC212	Void due to Subrogation
VRC214	Void due to Incorrect Patient/Member Information/Payment
VRC218	Void due to Incorrect Pricing/Provider Information/Payment
VRC220	Void due to Incorrect Pricing/Provider Information
VRC222	Void due to Medicare
VRC225	Void due to Void Denied until Money is recouped
VRC226	Void due to One Time Exception
VRC227	Void due to No Fault
VRC228	Void due to Medicare Audit
VRC230	Void due to Fraud/Abuse Recoupment
VRC231	Void due to Provider Appeal
VRC232	Void due to One Time Exception
VRC233	Void due to Provider Billing Error
VRC234	Void due to Member Appeal
VRC235	Void due to Rejected as Duplicate in Error
VRC236	Void due to Payment Made Due to Prompt Pay
VRC237	Valid Voids for Default Claim Includ in End to End
VRC238	Valid Voids for Default Claim Exclud in End to End
VRC239	Void due to RAP Claim - New Claim Required