

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
A01	YOUR CLAIM HAS BEEN REPROCESSED. TOTAL AMOUNT PAID HAS BEEN INCREASED.
A03	PRIOR PAYMENT DEDUCTED-PATIENT RESPONSIBLE FOR CHARGES
A04	PRIOR PAYMENT DEDUCTED-PATIENT NOT RESPONSIBLE FOR CHARGES
A05	CHARGE PROCESSED INCORRECTLY. CORRECTED CLAIM IN PROCESS.
A06	ENTIRE PAYMENT CREDITED TO REFUND ACCOUNT.
A07	REQUIRED AUDIT DOCUMENTATION NOT SUPPLIED - DO NOT BILL PATIENT.
A08	PROVIDER CANCELLED CHARGES - PATIENT NOT RESPONSIBLE FOR CHARGES.
A09	PAID TO INCORRECT PROVIDER - REPROCESSED TO CORRECT PROVIDER.
A11	PARTIAL PAYMENT CREDITED TO REFUND ACCOUNT.
A14	CHARGE PROCESSED INCORRECTLY. NEW CLAIM IN PROCESS.
A15	PAID TO INCORRECT MEMBER - REPROCESSED TO CORRECT MEMBER.
B01	MANDATORY 2ND SURGICAL OPINION NOT OBTAINED. PAYMENT REDUCED PER CONTRACT.
B02	SECOND SURGICAL OPINION REQUIRED PRIOR TO THIS SURGERY.
B03	MANDATORY 2ND SURGICAL OPINION NOT OBTAINED. PAYMENT REDUCED PER CONTRACT.
B04	PRE-ADMISSION APPROVAL NOT OBTAINED AND/OR NOT MEDICALLY NECESSARY.
B05	THE REQUIRED PRE-ADMISSION APPROVAL WAS NOT OBTAINED. PAYMENT REDUCED.
B06	SERVICES DO NOT MEET MEDICAL NECESSITY GUIDELINES.
B08	OUT-OF-AREA INPATIENT HOSPITAL PREADMISSION APPROVAL NOT OBTAINED.
B09	THIS CLAIM REQUIRES AN EPA (EXPEDITED PRIOR AUTHORIZATION) NUMBER.
B10	PRIOR HOSPITALIZATION OR 30 DAY TRANSFER REQUIREMENT NOT MET.
C01	THIS CLAIM HAS BEEN COORDINATED WITH YOUR PRIMARY INSURANCE COVERAGE.
C02	BENEFITS WERE COORDINATED WITH OTHER REGENCE PLAN.
C03	PAID FROM COORDINATION OF BENEFITS SAVINGS.
C04	PLEASE SEND CLAIMS PAYMENT EXPLANATION FROM OTHER CARRIER. WILL REPROCESS WHEN RECEIVED.
C06	MULTIPLE COVERAGE LETTER NOT ANSWERED - WILL REPROCESS IF RECEIVED.
C07	NOT COVERED BY YOUR CONTRACT. COVERED BENEFIT BY PRIMARY CARRIER.
C09	PLEASE SEND CLAIM PROCESSING EXPLANATION FROM YOUR OTHER CARRIER. WILL REPROCESS WHEN RECEIVED.
C10	MULTIPLE COVERAGE LTE NOT ANSWERED-WILL REPROCESS IF RECEIVED.
C11	PRIMARY INSURANCE PAYMENT EXCEEDS PRE-NEGOTIATED RATE.
C12	CLAIM CANNOT BE PROCESSED UNTIL PRIMARY INSURANCE HAS COMPLETED PROCESSING
C13	DUPLICATE COVERAGE IS NOT ALLOWED UNDER THE TERMS OF YOUR CONTRACT.
C14	ADD'L PAYMENT MADE TO REDUCE PATIENT RESP. USING DOLLARS ACCRUED TO COB SAVINGS AFTER ORIG. CLAIM WAS PAID.
C15	REFUND REQUESTED TO RECOVER MONEY PAID FROM COB SAVINGS (ACCRUED ON PREVIOUS CLAIM PAID IN ERROR.
C16	WE ARE UNABLE TO PROCESS THIS CLAIM WITHOUT THE COMPLETED MULTIPLE COVERAGE LETTER PREVIOUSLY SENT.
C17	DO ANY MEMBERS OF THE FAMILY HAVE DUPLICATE COVERAGE? PLEASE CALL CUSTOMER SRVC. AT 253-597-6557 WITH INFO
C18	DO ANY MEMBERS OF THE FAMILY HAVE DUPLICATE COVERAGE? PLEASE CALL CUSTOMER SRVC AT 253-597-6557 WITH INFO
C19	DO ANY MEMBERS OF THE FAMILY HAVE DUPLICATE COVERAGE? PLEASE CALL CUSTOMER SRVC AT 800-669-8791 WITH INFO
C20	DO ANY MEMBERS OF THE FAMILY HAVE DUPLICATE COVERAGE? PLEASE CALL CUSTOMER SRVC AT 800-669-8791 WITH INFO
C21	DO YOU HAVE ANY OTHER INSURANCE? PLEASE CALL OUR CUSTOMER SERVICE AT 1-888-344-6347 WITH INFORMATION.
C23	SEE ALTERNATE TEXT-PRESS PF12

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<b>Code</b>	<b>Description</b>
C24	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(800)458-3523 OR (206)464-3663.
C25	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(888)344-5587 OR (509)525-5220.
C26	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(800) 240-9580
C27	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(800) 240-9580
C28	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(800) 240-9560
C29	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(800) 240-9560.
C30	DO ANY ELIGIBLE FAMILY MEMBERS HAVE OTHER COVERAGE? PLEASE CALL US AT 1(800) 669-9715.
D01	DUPLICATE CHARGE-INDICATE IF CORRECTED BILL OR REVIEW REQUESTED & SUBMIT TO CLAIMS REVIEW WITH NOTES/RPTS.
D02	DUPLICATE CHARGE CURRENTLY IN PROCESS.
D03	DUPLICATE CHARGE-INDICATE IF CORRECTED BILL OR REVIEW REQUESTED & SUBMIT TO CLAIMS REVIEW WITH NOTES/RPTS
D04	DUPLICATE CHARGE CURRENTLY IN PROCESS.
D05	CLAIM BEING SUBMITTED BY VISTA OPTICAL.
D06	DUPLICATE SERVICE - ROI RECOVERY
D09	INTERMEDIARY ARRANGEMENT IN PLACE FOR THESE SERVICES.
D10	THIS CLAIM IS A DUPLICATE OF A CLAIM THAT HAS ALREADY BEEN PROCESSED AND PAID TO THE MEMBER DIRECTLY.
D11	THIS CLAIM IS A DUPLICATE OF A CLAIM THAT HAS ALREADY BEEN PROCESSED AND PAID TO THE PROVIDER DIRECTLY.
E01	COVERAGE NOT IN EFFECT FOR DATE OF SERVICE.
E03	PROCEDURE/TREATMENT STARTED PRIOR TO COVERAGE.
E04	MATERNITY ALLOWANCE PAID ONLY AT DELIVERY. RESUBMIT AFTER DELIVERY.
E05	NOT COVERED UNDER CONTRACT. SUBMIT TO OTHER CARRIER.
E06	THE REQUIRED WAITING PERIOD FOR THIS CONDITION HAS NOT BEEN MET.
E08	COVERAGE NOT IN EFFECT FOR DATE OF SERVICE.
E09	ELIGIBILITY VERIFICATION NOT RECEIVED FROM CONTROL PLAN.
E10	PREMIUM AND COVERAGE NOT CURRENT FOR DATE(S) OF SERVICE.
E11	DEPENDENT NOT LISTED ON COVERAGE. PLEASE CONTACT TOTAL ACCESS AT 1 (866) 4 73-2016.
E12	DEPENDENT NOT LISTED ON COVERAGE. PLEASE CONTACT TOTAL ACCESS AT 1 (866) 4 73-2016.
E13	REPLACEMENT OF TEETH EXTRACTED PRIOR TO COVERAGE ARE NOT COVERED.
E14	NEWBORN APPLICATION FORM NOT RECEIVED; SERVICES NOT COVERED.
E16	PREMIUM AND COVERAGE NOT CURRENT FOR DATE(S) OF SERVICE.
E17	REQUIRED PERIOD OF TIME FOR REPLACEMENT HAS NOT BEEN MET.
E18	COVERAGE TERMINATED-AT THE REQUEST OF EMPLOYEE
E19	COVERAGE TERMINATED-DEPENDENT SPOUSE COVERAGE FORM NOT RETURNED.
E21	NO RESPONSE TO REQUEST FOR VERIFICATION OF ELIGIBILITY. WE ARE UNABLE TO PROCESS THE CLAIM AT THIS TIME.
E22	THE 90-DAY WAITING PERIOD FOR PREVENTIVE CARE HAS NOT BEEN MET.
E24	DENTAL PROCEDURE IS SUBJECT TO CONTRACT WAITING PERIOD.
E26	PRIOR COVERAGE INFORMATION LETTER WAS NOT ANSWERED. WILL REPROCESS IF RECEIVED.
E38	NOT INCLUDED IN THE CLASS ACTION

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<b>Code</b>	<b>Description</b>
E40	GROUP TERMINATED. RUN-OUT PERIOD HAS EXPIRED.
E41	CLAIM WILL BE REPROCESSED IF DEPENDENT IS ADDED TO COVERAGE-BOEING ONLY
E43	CLAIMS CANNOT PROCESS WITHOUT A VALID MEXICAN FACTURA SEAL - PLEASE RESUBMIT CLAIM WITH SEAL.
F01	CALL SUBJECT TO CONTRACT CALL DEDUCTIBLE.
F02	CONTRACT CALL DEDUCTIBLE ALREADY SATISFIED.
G01	THIS PROCEDURE DENIED DUE TO OUT-OF-AREA PROGRAM GUIDELINES. CHARGES ARE PATIENT RESPONSIBILITY.
G02	THIS PROCEDURE DENIED DUE TO OUT-OF-AREA PROGRAM GUIDELINES. CHARGES ARE PROVIDER WRITE-OFF.
G03	PAYMENT REDUCED ACCORDING TO SUBSCRIBERS HOME PLAN PROCESSING GUIDELINES. PROVIDER WRITE-OFF.
G04	PROCESSED PER SUBSCRIBER'S HOME PLAN GUIDELINES.
G05	COINSURANCE/COPAYMENT/DEDUCTIBLE APPLIED TO MAXIMUM ALLOWANCE PER SUBSCRIBER'S CONTRACT.
G06	MISROUTED CLAIM (ITS)
G07	CLOSE OUT CLAIM (ITS)
G08	HANDLE DIRECT & PAY PROVIDER DIRECTLY
G09	HANDLE DIRECT & PAY SUBSCRIBER DIRECTLY.
G10	MEDICARE COMPLIMENTARY - HANDLE OUTSIDE ITS
G11	THIRD PARTY LIABILITY, HANDLE DIRECT
G12	CLOSE OUT FOR ADJUSTMENT SF
G13	COVERAGE NOT FOUND PER ITS HOME PROCESSING PLAN.
G14	CLAIM PROCESSING BEING HANDLED THROUGH SUBSCRIBERS HOME PLAN PER ITS OUT OF AREA PROGRAM GUIDELINES.
G15	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WRONG PAYEE. IF QUESTIONS CALL 206-464-5516.
G16	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WRONG SUBSCRIBER. IF QUESTIONS CALL 206-464-5516.
G17	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WRONG PROVIDER PAID. IF QUESTIONS CALL 206-464-5516.
G18	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WORKERS COMPENSATION. IF QUESTIONS CALL 206-464-5516.
G19	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-DUPLICATE. IF QUESTIONS CALL 206-464-5516.
G20	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-BENEFITS. IF QUESTIONS CALL 206-464-5516.
G21	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-RETROACTIVE CANCELLATION-IF QUESTIONS CALL 206-464-5516
G22	CLAIM ADJUSTED BY ITS OUT OF AREA GUIDELINES-LOST/DAMAGE CHECK, STOP PAYMENT. QUESTIONS CALL 206-464-5516
G23	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-MEDICARE. IF QUESTIONS CALL 206-464-5516.
G24	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-SUBROGATION. IF QUESTIONS CALL 206-464-5576.
G25	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-COB. IF QUESTIONS CALL 206-464-5516.
G26	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WRONG PAYEE.
G27	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WRONG SUBSCRIBER.
G28	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WRONG PROVIDER PAID.
G29	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-WORKERS COMPENSATION.
G30	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-DUPLICATE.
G31	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-BENEFITS.

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<b>Code</b>	<b>Description</b>
G32	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-RETROACTIVE CANCELLATION.
G33	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-LOST/DAMAGE CHECK, STOP PAYMENT.
G34	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-MEDICARE
G35	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-SUBROGATION.
G36	CLAIM ADJUSTED THROUGH ITS OUT OF AREA GUIDELINES-COB.
G37	SERVICE AREA BELONGS TO HOME AND HOST PLANS. CLOSE OUT CLAIM.
G38	POSSIBLE FRAUDULENT CLAIM.
G39	ERISA ACCOUNT. APPLICATION OF STATE MANDATES IS OPTIONAL.
G40	PRODUCT NOT ELIGIBLE FOR BLUE CARD PROGRAM DELIVERY.
G41	THIS SERVICE NOT A BENEFIT WHEN BILLED ALONE.
G42	NOT A BENEFIT UNDER THIS LINE OF BUSINESS.
G43	ANOTHER INSURANCE CARRIER HANDLES THESE SERVICES. PLEASE HANDLE DIRECT WITH OTHER CARRIER.
G44	ANOTHER INSURANCE CARRIER HANDLES THESE SERVICES. PLEASE HANDLE DIRECT WITH THE HOME PLAN.
G45	SUBSCRIBER HAS NOT RESPONDED TO OTHER COVERAGE INQUIRY.
G46	CLAIM DENIED BECAUSE THIS CARE IS THE LIABILITY OF THE NO FAULT CARRIER.
G48	ITS CLAIM SUBMITTED WITH WRONG ALPHA PREFIX FOR THE SUBSCRIBER.
G49	CLAIM ADJUSTED THROUGH ITS OUT OF AREA PROGRAM - INCORRECT SUBSCRIBER ID
G50	CLAIM ADJUSTED THROUGH ITS OUT OF AREA PROGRAM - PATIENT CHANGE
G51	CLAIM ADJUSTED THROUGH ITS PROGRAM - INCORRECT REJECT
G52	PAYMENT IS INCLUDED IN OUR PAYMENT FOR OTHER SERVICES PERFORMED ON THE SAME DAY BY THE SAME PROVIDER.
G53	SEND PHYSICIAN SERVICE REPORT WITH MEDICARE EOB FOR THIS CHARGE.
G54	DENTAL COVERAGE ONLY
G55	BLUESHIELD COVERAGE ONLY
G56	BLUE CROSS COVERAGE ONLY
G57	CLAIM/SERVICE IS UNDER REVIEW.
G58	CLAIM CLOSED UNTIL ADDITIONAL INFORMATION IS RECEIVED. PATIENT NOT RESPONSIBLE FOR BALANCE.
G59	CLAIM/SERVICE REVIEW IS COMPLETE.
G60	SF SUBMITTED WITH INCORRECT PAYMENT DISPOSITION CODE.
G61	CONTRACTED FUNDING AGREEMENT-SUBSCRIBER IS EMPLOYED BY THE PROVIDER OF SERVICES.
HHL	OUT-OF-POCKET EXPENSES PROCESSED IN ACCORDANCE WITH THE TERMS OF THE CLASS ACTION SETTLEMENT.
H03	SERVICE DENIED. NO REFERRAL RECEIVED FROM PRIMARY CARE PROVIDER.
H04	BENEFITS FOR SELF-REFERRED SERVICE HAVE BEEN EXPENDED.
H05	SELECTION OF PRIMARY CARE PROVIDER REQUIRED. PLEASE CONTACT MEMBER SERVICES AT 1-800-458-3523.
H06	PRIOR PLAN APPROVAL AND REFERRAL NOT OBTAINED.
H07	PRIOR PLAN APPROVAL NOT OBTAINED.
H09	CLAIM WAS SPLIT. PORTION OF SERVICES WERE PROCESSED ON SEPARATE CLAIM.
H10	NON-CONTRACTED PROVIDER - SERVICES NOT COVERED PER HEALTH SERVICES.
H11	SERVICES PROVIDED ARE OUTSIDE THE SCOPE OF REFERRAL FROM PCP.
H12	PRIOR PLAN APPROVAL NOT OBTAINED - DO NOT BILL PATIENT.
H15	THE REFERRING PROVIDER'S NAME IS NECESSARY TO PROCESS THIS CLAIM. WILL REPROCESS WHEN RECEIVED.
H16	NO REFERRAL FROM PRIMARY CARE PROVIDER. BENEFIT REDUCED TO EXTENDED-NETWORK PERCENTAGE.
H17	SERVICES PAID TO EXTENDED-NETWORK BENEFIT BECAUSE PATIENT DID NOT CHOOSE A

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	PRIMARY CARE PROVIDER.
H18	SERVICES PAID TO EXTENDED-NETWORK PERCENTAGE. REFERRAL RECEIVED IS FOR A PROVIDER OUTSIDE OF THE NETWORK.
H19	SERVICES COORDINATED THROUGH THE CARE MANAGER. PAID TO IN-NETWORK PERCENTAGE.
H20	SERVICES NOT COORDINATED THROUGH THE CARE MANAGER. PAID TO THE EXTENDED NETWORK PERCENTAGE.
H21	SERVICES PAID TO IN-NETWORK BENEFIT. COORDINATED WITH PRIMARY CARE PROVIDER OR CARE MANAGER.
H22	THIS SERVICE WAS NOT PRE-AUTHORIZED THROUGH VALUE OPTIONS. REFER QUESTIONS TO 1-800-892-1411
H23	CLAIM PAID AT LOWER BENEFIT; NO VALUE OPTIONS REFERRAL OBTAINED. REFER QUESTIONS TO 1-800-892-1411.
H24	MEDICAL NECESSITY HAS NOT BEEN ESTABLISHED. REFER QUESTIONS TO VALUE OPTIONS AT 1-800-892-1411.
H25	MEDICAL NECESSITY FOR THIS SERVICE HAS NOT BEEN ESTABLISHED. REFER QUESTIONS TO REGENCE CUSTOMER SERVICE.
H27	NO PCP ON FILE FOR THIS PATIENT. THEREFORE PREVENTIVE CARE RENDERED BY A SELECTIONS PROVIDER NOT COVERED.
H28	YOU HAVE ELECTED TO WAIVE THE SELECTION OF A PRIMARY CARE PHYSICIAN. BENEFITS REDUCED.
H29	PRIMARY CARE PHYSICIAN INFORMATION NOT RECEIVED. BENEFITS REDUCED.
H30	SERVICES NOT AUTHORIZED. BENEFITS REDUCED.
H31	SERVICES RENDERED BY A NON-NETWORK PROVIDER. BENEFITS REDUCED.
H32	SERVICES RENDERED BY NON-NETWORK PROVIDER NOT COVERED.
H33	PRESCRIPTION DRUGS NOT PURCHASED FROM A CONTRACTING PHARMACY. BENEFITS REDUCED.
H34	SERVICES NOT PROVIDED BY YOUR PRIMARY CARE PHYSICIAN. CLAIM DENIED.
H37	THIS PROVIDER HAS BEEN RECORDED AS YOUR PRIMARY CARE PROVIDER. IF INCORRECT, PLEASE CALL MEMBER SERVICES.
H39	CAPITATED SERVICE - CARE BY THE PCP OR COVERING PHYSICIAN.
H40	FEE FOR SERVICE - PAID TO HEALTHY OPTIONS ALLOWANCE.
H41	SERVICE NOT COVERED.- BILL DSHS.
H42	MEDICAL NECESSITY FOR THIS SERVICE HAS NOT BEEN ESTABLISHED. REFER QUESTIONS TO REGENCE CUSTOMER SVC.
H43	NO PCP AUTHORIZATION. CHARGE(S) NOT ALLOWED.
H44	SERVICE/CONDITION BILLED BY VALUE OPTIONS PROVIDER DIFFERS FROM AUTH. REFER QUESTIONS TO 1-800-892-1411.
H45	SERVICE/CONDITION BILLED BY NON-VALUE OPTIONS PROVIDER DIFFERS FROM AUTH. QUESTIONS CALL 1-800-892-1411.
H46	SERVICE BY NON-PSYCH PROVIDER IS NOT ELIGIBLE FOR HIGHER LEVEL OF PAYMENT. REFER QUESTIONS TO REGENCE.
H47	MEDICAL NECESSITY FOR THIS SERVICE NOT ESTABLISHED, REFER QUESTIONS TO CARE MANAGER AT 1-800-780-7881.
H49	REFERRAL VISITS, DATES OR PROCEDURES ARE EXHAUSTED. BENEFITS REDUCED.
H51	PROCEDURE BILLED BY THIS PROVIDER NOT AUTHORIZED BY MAGELLAN. REFER TO CARE MANAGER AT 1-800-780-7881.
H52	SERVICES REQUESTED BY A NON-NETWORK PROVIDER ARE NOT COVERED.
H53	MEDICAL NECESSITY HAS NOT BEEN ESTABLISHED. REFER QUESTIONS TO VALUE OPTIONS @ 1-800-892-1411.
H54	AUTHORIZATION FROM VALUE OPTIONS NOT OBTAINED. REFER QUESTIONS TO VALUE OPTIONS AT 1-800-892-1411.
H55	PROCEDURE CODES BILLED DO NOT MATCH PROCEDURE CODES ON REFERRAL REQUEST.

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<b>Code</b>	<b>Description</b>
H56	REFERRAL NOT RECEIVED FROM PROVIDER. PLEASE REFER QUESTIONS TO OUR BEHAVIORAL HEALTH DEPARTMENT (800) 780-7881.
H57	REFERRAL DENIED BY DELEGATED GROUP. SERVICES DENIED.
H58	SERVICES NOT COORDINATED WITH REGENGE BLUESHIELD. BENEFIT REDUCED TO EXTENDED-NETWORK PERCENTAGE.
H59	ONLY THE SCREENING FEE IS ALLOWED FOR ER LEVELS 1&2 UNLESS REFERRED BY THE PCP.
H60	CLAIM ADJUSTED. PLAN PROCEDURES OF A PRIOR PAYER WERE NOT FOLLOWED.
H61	CLAIM/SERVICE NOT COVERED/REDUCED BECAUSE ALTERNATIVE SERVICES WERE AVAILABLE AND SHOULD HAVE BEEN USED.
H62	REFERRING/ORDERING PHYSICIAN ON CLAIM CANNOT REFER MEMBER ** CLAIM DENIED
H63	THIS SERVICE /PROCEDURE IS INCONSISTENT WITH THE PATIENT'S AGE
H64	THIS SERVICE/PROCEDURE IS INCONSISTENT WITH THE PATIENT'S GENDER
H70	BENEFITS REDUCED BECAUSE A NATIONAL SPECIALITY CENTER PROVIDER WAS NOT UTILIZED FOR THE PROCEDURE.
IA1	BIRTHWEIGHT IS REQUIRED FOR PROCESSING.
IA2	NO CHARGE FOR THIS SERVICE PER PROVIDER BILLING INSTRUCTIONS
IA3	EPA # BILLED IS INCORRECT FOR THIS CPT CODE. PLEASE RESUBMIT WITH THE CORRECT EPA#.
IA5	CLAIM DENIED WILL REPROCESS WHEN RSN ASSESSMENT DENIAL IS RECIEVED.
IA6	EMERGENCY SERVICES RECORDS NEEDED BEFORE CLAIM CAN BE PROCESSED.
IA7	ONSET DATE NEEDED BEFORE CLAIM CAN BE PROCESSED.
IA8	STUDENT CERTIFICATION AND FULL TIME STUDENT STATUS INFORMATION NEEDED BEFORE CLAIM CAN BE PROCESSED.
IA9	DISCHARGE SUMMARY NEEDED BEFORE CLAIM CAN BE PROCESSED.
IB1	PAYMENT DIRECTION HAS BEEN CHANGED FROM PAY SUB TO PROVIDER DUE TO ACCT CONTRACTUAL OR LEGAL REQUIREMENT.
IB2	PAYMENT DIRECTION HAS BEEN CHANGED FROM PAY PROVIDER TO SUB DUE TO ACCT CONTRACTUAL OR LEGAL REQUIREMENT.
IB3	THE CLAIM HAS BEEN PAID USING A PRICE NEGOTIATED DIRECTLY WITH A NON-PAR PROVIDER.
IB4	THE CLAIM HAS BEEN PAID UP TO THE FULL CHARGE AMOUNT OR OTHER AMOUNT DUE TO ACCOUNT CONTRACTUAL REQ.
IB5	THE CLAIM HAS BEEN PAID UP TO THE FULL CHARGE AS IT IS LESS THAN THE PAR/HO OST LICENSEE'S ALLOWANCE.
IB6	THE CLAIM HAS BEEN PAID UP TO THE HOME LICENSEE'S ALLOWANCE BECAUSE IT IS LESS THAN THE HOST'S ALLOWANCE.
IB7	CLAIM HAS BEEN PAID UP TO THE FULL CHARGE AMOUNT BECAUSE THE PROVIDER WAS HOSPITAL BASED.
IB8	CLAIM HAS BEEN PAID UP TO THE FULL CHARGE AMOUNT BECAUSE THE SERVICES WERE DUE TO AN EMERGENCY.
IB9	CLAIM HAS BEEN PAID UP TO THE FULL CHARGE AMOUNT BECAUSE A PARTICIPATING PROVIDER WAS NOT ACCESSIBLE.
IC1	CLAIM HAS BEEN PAID UP TO THE FULL CHARGE AMOUNT DUE TO CONTINUITY OF CARE OR UM/CARE MANAGEMENT.
IC2	SERVICE HAS BEEN PAID AS AN EXCEPTION TO PATIENT'S CONTRACT. THIS EXCEPTION APPLIES TO THIS CLAIM ONLY.
IC3	CLAIM RECD WITHOUT YOUR NPI. AN NPI IS ON FILE, USE BOTH YOUR NPI AND RIDER NUMBER UNTIL FURTHER NOTICE.
I04	MEDICAL NECESSITY FOR THIS PROCEDURE MUST BE DOCUMENTED.
I06	REQUIRED REPORT OR ADDITIONAL INFORMATION REQUESTED NOT RECEIVED. CLAIM WILL BE ADJUSTED UPON RECEIPT.
I07	PRIOR CARRIER CREDIT

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I09	CHARGES NOT A BASIC CONTRACT BENEFIT. SUBMIT TO THE MAJOR MEDICAL CARRIER.
I11	DEPENDENT IS NOT LISTED ON THE SUBSCRIBER'S CONTACT.
I14	PLEASE SUBMIT THIS CLAIM TO YOUR HOME PLAN.
I15	INPATIENT STAY NOT APPROVED. BENEFITS HAVE BEEN REDUCED.
I21	THIS IS A CONTRACTUAL ALLOWANCE WRITE-OFF.
I23	PLEASE SUBMIT CLAIMS FOR PRESCRIPTION DRUGS TO PRESCRIPTION DRUG VENDOR.
I29	NOT ALLOWED FOLLOWING MEDICAL REVIEW - DO NOT BILL PATIENT.
I30	SUPPLY NOT COVERED FOLLOWING MEDICAL REVIEW.
I32	PRE-ADMISSION APPROVAL NOT OBTAINED AND ADMIT NOT MEDICALLY NECESSARY.
I34	NUMBER OF VISITS AUTHORIZED BY REFERRAL HAVE BEEN EXPENDED.
I35	CHARGES DENIED BECAUSE DRUG RECEIPTS WERE NOT ATTACHED. CLAIM WILL BE REPROCESSED WHEN RECEIVED.
I36	NO REPLY TO OUR PRE-EXISTING CONDITION LETTER. CLAIM WILL BE REPROCESSED WHEN RECEIVED.
I37	SERVICES PERFORMED AFTER RECORDED DEATH.
I38	CONVERTED HISTORY CLAIM - BALANCING PROBLEM
I39	PLEASE RESUBMIT USING CORRECT CPT IV CODE FOR SERVICES RENDERED.
I40	DO NOT AUTO-REJECT CLAIM AS DUPLICATE.
I41	PREVIOUSLY APPLIED TO DEDUCTIBLE.
I42	LOCAL PLAN ALLOWANCE-IF OTHER PLAN'S FEE IS HIGHER ADDITIONAL PAYMENT WILL FOLLOW.
I43	OUTPATIENT ROOM CHARGES IN EXCESS OF THE SEMI-PRIVATE ROOM RATE ARE NOT COVERED.
I47	REIMBURSEMENT OF DEDUCTIBLE/COPAYMENT PER SEATBELT/HELMET INCENTIVE.
I49	HOSPITAL OUTLIER/STOPLOSS MET. CLAIM ADJUSTED PER AGREEMENT WITH PROVIDER.
I50	INFORMATION REQUESTED FROM YOUR PROVIDER WAS NOT RECEIVED BY VBH. PLEASE CONTACT YOUR PROVIDER.
I51	REQUEST REFUND FOR CONTRACTUAL DIFFERENCE FROM VISTA OPTICAL, 1-800-776-8116 EXT 41.
I52	MEDICAL DOCUMENTATION NOT SUPPLIED AS REQUESTED. DO NOT BILL PATIENT
I53	MEDICAL DOCUMENTATION REQUESTED IS INCOMPLETE. DO NOT BILL PATIENT.
I57	IF YOU WISH US TO RECONSIDER THIS SERVICE, PLEASE RE-BILL WITH THE COMPLETE CHART NOTES.
I58	INFO REQUESTED FROM VALUE OPTIONS NOT RECVD. WILL REPROCESS IF RECVD. REFER QUESTIONS TO 1-800-892-1411.
I59	WILLAMETTE DENTAL GROUP REFERRAL. PLEASE CONTACT WILLAMETTE DENTAL GROUP FOR PROCESSING. 1-800-360-1909.
I61	STERILIZATION CONSENT FORM NOT SUBMITTED - WILL REPROCESS IF RECEIVED.
I64	ALLOWED AMOUNT DETERMINED FOR THIS PROCEDURE FOLLOWING REVIEW.
I65	PROCEDURE NOT ALLOWED AFTER REVIEW.
I66	PLEASE SUBMIT MEDICAL NECESSITY DOCUMENTATION FOR THIS PROCEDURE.
I67	CHARGE NOT ALLOWED AFTER REVIEW.
I68	MAXIMUM ALLOWANCE PAID FOR THIS PROCEDURE.
I69	MAXIMUM ALLOWANCE FOR THIS SERVICE ALREADY PAID.
I72	ALLOWED INCLUDES CUSTOMARY CHARGE FOR PROVIDER'S AREA & HOSPITAL OUTLIER.
I73	ADDITIONAL INFORMATION NEEDED FOR CARE REVIEW. PLEASE CONTACT THE CARE MANAGER AT 1-800-780-7881.
I74	REQUIRED REPORT, ITEMIZATION, OR DESCRIPTION NOT RECEIVED. CLAIM WILL BE REPROCESSED WHEN RECEIVED.
I75	REQUIRED REPORTS/ITEMIZATION AND/OR REQUESTED ADDITIONAL INFO NOT RECEIVED- WILL REPROCESS WHEN RECEIVED.

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I79	THE DIAGNOSIS CODE BILLED IS INCONSISTENT WITH THE PROCEDURE/SERVICE BILLED
I80	PRE AUTHORIZATION NOT RECEIVED FROM CONTRACTED PROVIDER.
I81	THE EOB RECEIVED DOES NOT MATCH THE CLAIM SUBMITTED-WILL REPROCESS WHEN THE CORRECT INFO IS RECEIVED.
I84	REQUIRED INJURY INFORMATION NOT PROVIDED - WILL REPROCESS WHEN RECEIVED.
I85	CPT CODES AND MEDICARE ALLOWED AMOUNTS ARE NEEDED TO PROCESS THE CLAIM.
I86	PLEASE SUBMIT THE INVOICE FOR THIS ITEM/SUPPLY
I87	PLEASE RESUBMIT THIS CLAIM WITH A VALID NATIONAL DRUG CODE (NDC) NUMBER.
I88	MEDICAL NECESSITY FOR PRIVATE ROOM ESTABLISHED. PROVIDER'S PAYMENT HAS BEEN INCREASED.
I89	RESUBMIT USING CPT CODE FOR CONSIDERATION UNDER THE MEDICAL PLAN
I90	THERAPY ORDERS HAVE BEEN REQUESTED FROM YOUR PROVIDER. CLAIM WILL BE REPROCESSED WHEN RECEIVED.
I91	PRESCRIPTION DRUGS ARE NOT COVERED WHEN BILLED ALONE. USE DRUG CARD OR INCLUDE WITH OTHER SERVICES.
I92	THIS DIAGNOSIS CODE IS NOT VALID WHEN BILLED AS THE PRIMARY DIAGNOSIS.
I93	NO RESPONSE FOR PRE-EXIST INFORMATION FROM PRIMARY PROVIDER.CLAIMS WILL BE REPROCESSED UPON RECEIPTS.
I94	HOSPITAL OUTLIER/STOPLOSS PAYMENT INCLUDED
I95	RESUBMIT WITH COPY OF ANESTHESIA OR CONSCIOUS SEDATION PERMIT. WILL REPROCESS WHEN RECEIVED.
I96	X-RAY AND DESCRIPTION RELATIONSHIP IS INCONSISTENT. PLEASE RESUBMIT WITH CLARIFICATION.
I97	DESCRIPTION OR CHARTING IS MISSING OR INADEQUATE TO DETERMINE BENEFIT.
I98	PROCEDURE DENIED FOLLOWING DENTAL CONSULTANT REVIEW. XRAY NOT READABLE.
I99	PLEASE SUBMIT THE INITIAL EVALUATION AND THERAPY NOTES FOR THE PAST SIX MONTHS OF TREATMENT
L01	HEALTHY OPTIONS FUNDS EXPENDED.
L02	SERVICE NOT COVERED UNDER HEALTHY OPTIONS. BILL DSHS DIRECTLY.
L03	STERILIZATION CONSENT FORM IS INVALID OR INCOMPLETE.
L05	POSSIBLE OTHER PARTY LIABILITY. CLIENT HAS NOT RETURNED INCIDENT REPORT; PAYMENT MAY BE RECLAIMED.
L06	CLAIM INDICATES POSSIBLE OTHER PARTY LIABILITY. PAYMENT MAY BE RECLAIMED.
L07	INVALID CODE COMBINATION. REFER TO MAA GUIDELINES.
L08	SUPPLY INCLUDED IN OFFICE CALLS.
L09	SUPPLY INCLUDED WITH PROCEDURE.
L10	POOL REQUESTED NOT ESTABLISHED. PLEASE CONTACT YOUR MSO.
L11	STOPLOSS EXCEEDED.
L12	CLAIM IN PROCESS.
L13	CLAIM SUSPENDED DUE TO MISSING DIAGNOSIS INFORMATION.
L14	CLAIM SUSPENDED DUE TO MISSING DATE OF SERVICE INFORMATION.
L15	CLAIM SUSPENDED DUE TO MISSING PLACE OF SERVICE INFORMATION.
L16	CLAIM SUSPENDED DUE TO MISSING CPT INFORMATION.
L17	CLAIM SUSPENDED DUE TO MISSING CHARGE INFORMATION.
L18	CLAIM SUSPENDED PENDING MEDICAL REVIEW.
L19	CPT CODE NOT ALLOWED FOR PLACE OF SERVICE SUBMITTED ON CLAIM FORM.
L20	DSHS FEE SCHEDULE PAYMENT INCREASED PER MSO AGREEMENT.
L21	DSHS FEE SCHEDULE PAYMENT DECREASED PER MSO AGREEMENT.
L22	SERVICE INCLUDED IN GLOBAL FEE.
L23	SERVICE NOT COVERED BY H.O. CONTRACT. PATIENT MAY ONLY BE BILLED IF WAIVER SIGNED BEFORE SERVICE RENDERED
L24	COVERAGE FOR THESE SERVICES DENIED. NO AUTHORIZATION BY PCP.
L25	PROCEDURE CODE OR SERVICE ASSIGNED TO A HOLD OR RESERVE FUND POOL.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
L26	CODE SUBMITTED WITHOUT CORRECT MODIFIER. MODIFIER ADDED OR CHANGED TO ALLOW CORRECT PROCESSING.
L27	ADJUSTMENT - ORIGINAL PROCESSING CORRECTED.
L28	PLEASE RESUBMIT USING CORRECT DSHS STATE LOCAL CODE FOR SERVICES RENDERED.
L29	NOT COVERED UNDER 'H' KIDS. BILL DSHS DIRECT.
L31	CLAIM IS BEING PROCESSED FOR H-PROGRAM CLIENT.
L32	CLAIM BEING REPROCESSED TO PAY FROM A CAPITATED FUND POOL.
L33	CLAIM BEING REPROCESSED TO PAY FROM A FEE FOR SERVICE FUND POOL.
L34	PAID UNDER INCORRECT MEMBER NUMBER/REPROCESSED UNDER CORRECT MEMBER.
L35	PAID UNDER MOTHER'S MEMBER NUMBER/REPROCESSED UNDER NEWBORN MEMBER NUMBER.
L37	DUPLICATE SERVICE ADJUDICATED. THIS IS A CORRECTING ADJUSTMENT.
L38	YOUR CLAIM HAS BEEN REPROCESSED. TOTAL AMOUNT PAID HAS BEEN DECREASED.
L39	PLEASE RESUBMIT USING VALID/CORRECT TAX ID NUMBER.
L40	SERVICES NOT PROVIDED BY A PCP BUT ALLOWED WITHOUT A REFERRAL
L42	PLEASE SEND CLAIMS PAYMENT EXPLANATION FROM OTHER CARRIER. PENDING CLAIM FOR 30 DAYS.
M01	MAXIMUM CONTRACT BENEFIT EXPENDED.
M02	BENEFIT EXPENDED WITH THIS CLAIM. BALANCE PAID AT CONTRACT PERCENTAGE.
M03	ROUTINE EYE EXAM BENEFIT EXPENDED.
M04	ROUTINE HEARING EXAM BENEFIT EXPENDED.
M06	MAXIMUM CONTRACT BENEFIT ALLOWANCE.
M07	MAXIMUM PAID BASIC. CHARGES TO SUPPLEMENTAL FOR PROCESSING.
M08	DENTAL PROCEDURE NOT COVERED. MAXIMUM PAID FOR A LESSER PROCEDURE.
M09	MAXIMUM PAID - SUPPLIES NOT COVERED BY CONTRACT.
M10	MAXIMUM CONTRACT ALLOWANCE FOR X-RAY AND LAB HAS BEEN EXPENDED.
M11	CHARGES IN EXCESS OF THE SEMI-PRIVATE ROOM RATE ARE NOT COVERED.
M19	MAXIMUM CONTRACT VISITS EXPENDED.
M20	MAXIMUM RENTAL ALLOWANCE HAS BEEN EXPENDED.
M21	MAXIMUM NUMBER OF DAYS/UNITS FOR THIS PRESCRIPTION EXCEEDED.
M22	MAXIMUM LIFETIME BENEFIT EXHAUSTED
M23	MAXIMUM PAID. BALANCE NOT COVERED BECAUSE MAXIMUM LIFETIME BENEFIT EXHAUSTED.
M24	MAXIMUM ALLOWANCE PER ORTHO OFFICE TREATMENT AGREEMENT (PHASE ONE).
M25	ONLY ONE SET OF EYEGLASSES OR CONTACT LENSES IS PAYABLE AFTER INTRA-OCULAR SURGERY OR OCULAR INJURY.
M27	LIFETIME TRANSPLANT BENEFIT EXHAUSTED.
M28	LIFETIME TRANSPLANT BENEFIT MET WITH THIS CLAIM. BALANCE PAID AT CONTRACT PERCENTAGE.
M29	MAXIMUM ALLOWABLE AMOUNT PER PROVIDERS FEE SCHEDULE.
M32	THE MAXIMUM NUMBER OF SERVICES APPROVED BY VBH HAVE BEEN EXPENDED. REFER QUESTIONS TO VBH 1-800-892-1411.
M33	NUMBER OF SERVICES APPROVED BY CARE MANAGER HAVE BEEN EXPENDED. REFER QUESTIONS TO REGENCE CUSTOMER SVC.
M35	YOUR BENEFIT LIMIT HAS BEEN REACHED WITH THIS CLAIM.
M36	BENEFIT EXHAUSTED. MAXIMUM OF TWO SERVICES EACH CALENDAR YEAR.
M42	BENEFIT EXHAUSTED. SCALING AND ROOT PLANING IS LIMITED TO ONCE PER CALENDAR YEAR.
M43	SERVICES AUTH'D BY VALUE OPTIONS EXPENDED BY NON-VALUE OPTIONS PROVIDER. REFER QUESTIONS TO 800-892-1411.
M44	SERVICES AUTH'D BY VALUE OPTIONS EXPENDED BY VALUE OPTIONS PROVIDER. REFER QUESTIONS TO 1-800-892-1411.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
M45	SERVICES AUTHORIZED BY CARE MANAGER HAVE BEEN EXPENDED. REFER QUESTIONS TO REGENCE CUSTOMER SERVICE.
M46	DATES OF SERVICE FROM NON-VBH PROVIDER EXCEED DATES AUTHORIZED BY VBH-REFER QUESTIONS TO VBH 800-892-1411
M47	MAXIMUM NUMBER OF SERVICES APPROVED HAVE BEEN EXPENDED, REFER QUESTIONS TO CARE MANAGER AT 1-800-780-7881
M49	REFERRAL VISITS, DATES, OR PROCEDURES ARE EXPENDED. CHARGES NOT ALLOWED.
M50	PURCHASE PRICE OF DURABLE MEDICAL EQUIPMENT HAS BEEN MET.
M53	ORTHODONTIA LIFETIME MAXIMUM HAS BEEN EXHAUSTED.
M54	SERVICE EXCEEDS BENEFIT. CONTRACT LIMITS THIS DENTAL PROCEDURE TO TWICE EVERY 1 CALENDAR YEAR.
M55	SEALANT EXCEEDS ONCE EVERY 3 CALENDAR YEAR LIMITATION AND/OR IS COVERED ONPERMANENT BICUSPID/MOLAR TEETH
M56	SERVICE EXCEEDS BENEFIT. CONTRACT LIMITS THIS DENTAL PROCEDURE TO ONCE EVERY 2 CALENDAR YEARS.
M57	MAXIMUM CONTRACT BENEFIT ALLOWANCE.
M58	MAXIMUM ALLOWABLE AMOUNT PER PROVIDERS FEE SCHEDULE.
M60	MAXIMUM BENEFIT FOR NON-NETWORK MENTAL HEALTH HAS BEEN EXPENDED.
M61	PROCEDURE DENIED. PER CONTRACT, LIMIT OF ONE ABUTMENT TOOTH PLACED ON EACH SIDE OF THE MISSING TOOTH.
M62	SERVICE EXCEEDS BENEFIT. CONTRACT LIMITS THIS DENTAL PROC. TO ONCE EVERY 3 CALENDAR YEARS.
M63	SERVICE EXCEEDS BENEFIT. CONTRACT LIMITS THIS DENTAL PROCEDURE TO ONCE EVERY 5 CALENDAR YEARS.
M64	MAXIMUM BENEFIT PAID FOR AN ALTERNATE PROCEDURE.
M65	CHARGES IN EXCESS OF THE SEMI-PRIVATE ROOM RATE ARE NOT COVERED.
M66	SERVICE EXCEEDS BENEFIT. FULL MOUTH SCALING AND ROOT PLANING IS LIMITED TO ONCE EVERY 2 CALENDAR YEARS.
M67	DENTAL PROCEDURE HAS NOT MET THE 7-YEAR-REPLACEMENT CONTRACT LIMITATION.
M68	SERVICE EXCEEDS BENEFIT. CONTRACT LIMITS TO ONE SET OF BITEWING X-RAYS EVERY 1 CALENDAR YEAR.
M69	SEALANT EXCEEDS ONCE EVERY 4 CALENDAR YEAR LIMITATION AND/OR IS COVERED ON PERMANENT BICUSPID/MOLARS.
M70	DENTAL PROCEDURE HAS NOT MET THE 2 YEAR REPLACEMENT CONTRACT LIMITATION.
NB6	DENTAL IMPLANTS AND ASSOCIATED SURGICAL PROCEDURES ARE CONTRACT EXCLUSIONS.
NB7	COSMETIC DENTISTRY IS A CONTRACT EXCLUSION.
NCB	THIS BENEFIT IS NOT PROVIDED BY REGENCE BLUESHIELD. CONTACT VISION BENEFIT OF AMERICA AT 800-432-4966.
NCC	PROCEDURE CODE DENIED BASED ON INDUSTRY STANDARD CODING.
NCE	PROCEDURE CODE DENIED BASED ON INDUSTRY STANDARD CODING.
NC1	THIS MEDICATION IS NOT COVERED BY YOUR DRUG PLAN WITHOUT PRIOR AUTHORIZATION.
NC2	IV SEDATION IS NOT COVERED FOR THIS DENTAL PROCEDURE.
NC3	OCCLUSAL/NIGHTGUARD IS A CONTRACT EXCLUSION.
NC5	UNABLE TO PROCESS PROCEDURE UNTIL GENERAL ANESTHESIA OR CONSCIOUS SEDATION PERMIT IS RECEIVED.
NC6	PRESCRIPTION DRUG COPAYS ARE NOT COVERED.
NC7	THIS BENEFIT IS NOT PROVIDED BY REGENCE BLUESHIELD. CONTACT VISION SERVICE PLAN AT 1-800-877-7195.
NC8	PROCEDURE CODE IS NOT A VALID A.D.A. CODE. PLEASE REFER TO THE CURRENT C.D.T. BOOK.
NC9	THIS SUPPLY NOT COVERED WHEN DISPENSED FROM A PHYSICIAN'S OFFICE. ONLY

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
	SCREENING FEE WAS PAID.
ND0	REVIEW IS NEEDED TO DETERMINE IF THIS MEDICATION IS COVERED. PLEASE CONTACT MEDCO AT 1-800-841-2797.
ND1	MAINTENANCE THERAPY IS NOT COVERED UNDER YOUR PLAN.
ND3	YOUR CLAIM IS FOR A REFILL THAT WAS DISPENSED SOONER THAN YOUR PLAN COVERAGE ALLOWS.
ND4	CHARGES FOR OUTPATIENT SERVICES WITH THIS PROXIMITY TO INPATIENT SERVICES ARE NOT COVERED.
ND5	SERVICES NOT COVERED BECAUSE THE PATIENT IS ENROLLED IN A HOSPICE.
ND6	THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER.
ND7	MEMBER CONTRACT DOES NOT COVER THIS SERVICE WHEN RENDERED BY THIS PROVIDER TYPE OR SPECIALTY.
ND8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S AGE.
ND9	LOCUM TENENS NOT ALLOWED FOR THIS PROVIDER TYPE.
NE1	PRESCRIPTIONS PURCHASED OUTSIDE THE USA ARE NOT COVERED BY THIS PLAN.
NE2	PRESCRIPTION DRUG CHARGE IS LESS THAN COPAY AMOUNT.
NE3	BENEFITS NOT AVAILABLE BECAUSE A NATIONAL SPECIALITY PROVIDER WAS NOT UTILIZED FOR THE PROCEDURE.
NHH	REQUIRED CLAIM DOCUMENTATION NOT SUPPLIED.
NLW	SERVICES RENDERED BY THIS PROVIDER ARE NOT ELIGIBLE FOR REIMBURSEMENT UNDER THE CLASS ACTION.
N01	NOT COVERED BY CONTRACT.
N02	ROUTINE, PREVENTIVE OR ELECTIVE CARE NOT COVERED.
N03	THIS PROVIDER IS NOT COVERED UNDER THIS CONTRACT.
N04	THIS PROVIDER IS NOT COVERED FOR THIS PROCEDURE.
N06	PAYMENT CANNOT BE MADE FOR INCOMPLETE TREATMENT.
N07	CONDITION NOT COVERED BY CONTRACT.
N08	THIS SERVICE/PROCEDURE IS NOT A CONTRACT BENEFIT.
N09	FACILITY CHARGES ARE NOT COVERED BY CONTRACT.
N10	THIS LABORATORY PROCEDURE IS NOT COVERED BY CONTRACT.
N12	THIS SERVICE PAYABLE AS AN OUTPATIENT ONLY.
N13	PATIENT IS OVER THE CONTRACT AGE LIMIT FOR FLUORIDE TREATMENT.
N14	TREATMENT NOT PRE-AUTHORIZED.
N15	THIS XRAY PROCEDURE IS NOT COVERED BY CONTRACT.
N16	NO ORTHODONTIC BENEFITS PROVIDED BY CONTRACT.
N17	NOT COVERED BY CONTRACT. CHARGES SUBMITTED TO YOUR OTHER CARRIER.
N18	OVER THE COUNTER DRUGS ARE NOT A CONTRACT BENEFIT.
N20	NON CONTRACTING HOSPITALS ARE NOT COVERED BY THE CONTRACT.
N22	THIS SERVICE FOR THIS CONDITION IS NOT COVERED BY YOUR PLAN.
N23	THIS SUPPLY IS NOT COVERED.
N24	THIS SERVICE/PROCEDURE IS NOT COVERED.
N25	REFERRING PROVIDER IS NON-PARTICIPATING.
N26	MASSAGE THERAPY WITHOUT MANIPULATION NOT WITHIN SCOPE OF LICENSE.
N27	MEDICAL NECESSITY FOR THIS SERVICE OR SUPPLY HAS NOT BEEN ESTABLISHED.
N28	DRUGS DISPENSED IN THE DOCTOR'S OFFICE ARE NOT COVERED.
N30	SERVICES NOT COVERED. NOT A BASIC HEALTH PLAN PROVIDER.
N31	TAKE HOME PHARMACY NOT COVERED BY PATIENT'S CONTRACT.
N32	SERVICES OF A NON-PARTICIPATING PROVIDER ARE NOT COVERED.
N33	DENTAL SERVICES ARE NOT COVERED BY YOUR CONTRACT.
N34	PROCEDURE NOT COVERED FOLLOWING DENTAL CONSULTANT'S REVIEW.
N35	A NON-PPO PROVIDER IS NOT PAYABLE UNDER THIS CONTRACT.
N37	SELF INFLICTED INJURIES ARE NOT COVERED UNDER THE CONTRACT.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
N38	SUBSTANCE ABUSE IS NOT COVERED UNDER THE CONTRACT.
N39	SUBSTANCE ABUSE AND SELF INFLICTED INJURIES ARE NOT COVERED UNDER THE CONTRACT.
N40	GESTURES TO CAUSE A SELF INFLICTED INJURY ARE NOT COVERED UNDER THE CONTRACT.
N41	ROUTINE VISITS ARE PAYABLE ONLY WHEN RENDERED BY A PREFERRED PHYSICIAN.
N43	PRESCRIPTION DRUGS WERE NOT PURCHASED FROM A NETWORK PHARMACY.
N44	PRESCRIPTION DRUGS ARE NOT COVERED WHEN THE PRESCRIPTION ID CARD IS NOT PRESENTED AT THE TIME OF SERVICE.
N45	SERVICES NOT COORDINATED THROUGH CARE MNGR ARE NOT COVERED. REFER QUESTIONS TO REGENCE CUSTOMER SERVICE.
N46	PRESCRIPTION DRUGS WERE NOT PURCHASED FROM A CONTRACTING PHARMACY.
N47	PREVENTIVE CARE SERVICES RENDERED BY A NON-NETWORK PROVIDER ARE NOT A COVERED BENEFIT.
N49	ASSISTANT CHARGES NOT PAYABLE TO SURGEON. ASSISTANT REQUIRED TO BILL UNDER OWN RIDER NUMBER.
N52	PREVENTIVE CARE SERVICES NOT RENDERED BY THE PATIENTS PCP ARE NOT A COVERED BENEFIT.
N53	NEEDLES AND SYRINGES ARE NOT COVERED UNLESS PURCHASED WITH A COVERED INJECTABLE DRUG.
N54	REIMBURSEMENT FOR PRESCRIPTION DRUGS IS LIMITED TO A 90 DAY SUPPLY.
N55	PATIENT IS OVER THE CONTRACT AGE LIMIT FOR SEALANT TREATMENT
N56	TREATMENT NOT COVERED. CONTRACT REQUIRES TREATMENT TO BE RENDERED AT A WILLAMETTE DENTAL GROUP CLINIC.
N57	NOT A BENEFIT SUBSCRIBER IDENTIFICATION CARD NOT SHOWN AT TIME OF PURCHASE.
N58	SERVICE NOT PREAUTHORIZED THROUGH CARE MANAGER. REFER QUESTIONS TO REGENCE CUSTOMER SERVICE.
N60	NOT COVERED BY THE BHP PLUS CONTRACT. BILL DSHS DIRECTLY.
N61	THIS BENEFIT IS NOT COVERED BY THE BHP CONTRACT. PLEASE BILL DSHS.
N62	THIS SERVICE IS NOT COVERED BECAUSE IT WAS RENDERED BY A U.S. GOVERNMENT DEBARRED OR EXCLUDED PROVIDER.
N63	NON-EMERGENCY CARE OUTSIDE WASHINGTON STATE NOT COVERED BY CONTRACT.
N64	NO REFERRAL FROM A PREFERRED PLAN PHYSICIAN. CLAIM DENIED.
N65	SERVICES NOT PREAUTHORIZED BY THE CARE MANAGER. REFER QUESTIONS TO THE CARE MANAGER AT 1-800-780-7881.
N67	CHARGE NOT ALLOWED AND OR LIMITED TO ONE SERVICE EVERY 30 DAYS.
N68	NOT A SELECTMED PROVIDER. PATIENT IS RESPONSIBLE FOR PAYMENT.
N69	THIS MEDICATION IS NOT COVERED BY YOUR DRUG CARD PLAN.
N70	RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT MUST BE OBTAINED FROM A CONTRACTING PROVIDER.
N71	SERVICES PROVIDED BY A FAMILY MEMBER ARE NOT PAYABLE.
N72	DENTAL PROCEDURE IS NOT INCLUDED IN THE BENEFIT CONTRACT.
N73	GENERAL ANESTHESIA NOT COVERED FOR THIS DENTAL PROCEDURE.
N81	ONLY TRANSPORTATION TO THE CLOSEST FACILITY THAT CAN PROVIDE THE NECESSARY CARE IS COVERED.
N91	THIS PLAN DOES NOT PAY FOR COSMETIC SURGERY AND RELATED SERVICES.
PNB	THIS CLAIM FOR A NEWBORN WAS PROCESSED UNDER THE MOTHER'S ELIGIBILITY.
P01	PAID AT CONTRACT PERCENTAGE OF MAXIMUM ALLOWABLE FEE.
P02	PAID AT CONTRACT PERCENTAGE OF CHARGE.
P03	ALLOWED AMOUNT PAID AT CONTRACT PERCENTAGE
P05	PAID AT CONTRACT PERCENTAGE OF MAXIMUM ALLOWANCE.
P07	PAID TO CONTRACT PERCENTAGE FOR NON-PREFERRED PROVIDER.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
P08	PAYMENT REDUCED BY COPAYMENT AMOUNT.
P10	PAYMENT % BASED ON ASSIGNED WORK LOCATION. ANY QUESTIONS CALL 206 655-2391
P11	SWEDISH MEDICAL CENTER WILL NOT CHARGE YOU THE 20% CO-INSURANCE DUE FOR SERVICES RECEIVED AT SMC.
P12	PAID TO IN-NETWORK PERCENTAGE.
P13	PAID TO EXTENDED-NETWORK PERCENTAGE.
P14	PAID TO OUT-OF-SERVICE AREA PERCENTAGE.
P15	PAID TO MANAGED BEHAVIORAL HEALTH MAXIMUM ALLOWED.
P16	PAID TO THE DISCOUNTED MAXIMUM ALLOWANCE FOR THE UW STUDENT PLAN.
P18	THIS FEP PREFERRED DENTAL PROVIDER HAS AGREED TO ACCEPT THE MAXIMUM ALLOWABLE CHARGE (MAC).
P19	PAID TO BASIC HEALTH PLAN MAXIMUM ALLOWANCE.
P20	THIS SERVICE PAID TO YOUR DENTAL INJURY BENEFIT.
P21	UNDER FEDERAL LAW (5 U.S.C. 8904(B)) PATIENT IS NOT RESPONSIBLE FOR AMOUNT OVER MEDICARE FEE SCHEDULE.
P22	UNDER FEDERAL LAW (5 U.S.C. 8904(B)) PATIENT IS NOT RESPONSIBLE FOR AMOUNT OVER MEDICARE LIMITING CHARGE.
P24	PAID TO MANAGED BEHAVIORAL HEALTH MAXIMUM.
P28	AMALGAM/GOLD MATERIAL ALLOWANCE PROVIDED FOR POSTERIOR TEETH.
P30	AMALGAM OR COMPOSITE FILLING ALLOWANCE PROVIDED PER DENTAL CONSULTANT REVIEW.
P32	INLAY AND GOLD FOIL ARE CONTRACT EXCLUSIONS. AMALGAM ALLOWANCES PROVIDED FOR THESE PROCEDURES.
P34	PAYMENT HAS BEEN REDUCED DUE TO PLACE OF SERVICE.
P35	LIMITING CHARGE-SEE ALTERNATE TEXT(PF12)
P36	AMBULANCE CHARGES PAID AT HOSPITAL CONTRACT LEVEL.
P37	PREVIOUS PALLIATIVE PAYMENT REDUCED FROM ROOT CANAL TREATMENT WHEN DONE WITHIN 6 MONTHS.
P38	JOINT PAYEE CHECK ISSUED AS PROVIDED BY WA STATE LAW. PLEASE ENDORSE & FORWARD TO THE PROVIDER OF SERVICE
P40	DISCHARGE DATE IS AFTER COVERAGE CANCELLATION. PRICED TO PERCENTAGE OF CHARGE.
P41	ADMIT DATE IS PRIOR TO COVERAGE EFFECTIVE DATE. PRICED TO PERCENTAGE OF CHARGE.
P43	BRAND DRUG PAID TO THE GENERIC DRUG BENEFIT.
P50	THE PAYMENT ON THIS CLAIM INCLUDES A PERSONAL SAVINGS ACCOUNT BEING MADE ON BEHALF OF THE MEMBER.
Q01	CHARGES NOT ALLOWED FOLLOWING EXTERNAL AUDIT REVIEW; DO NOT BILL PATIENT.
Q02	CHARGES NOT ALLOWED FOLLOWING EXTERNAL AUDIT REVIEW; PATIENT IS RESPONSIBLE FOR BALANCE.
Q03	REQUIRED EXTERNAL AUDIT DOCUMENTATION NOT SUPPLIED; DO NOT BILL PATIENT.
Q07	DOCUMENTATION SUBMITTED HAS NOT SATISFIED EXTERNAL AUDIT REQUIREMENTS. DO NOT BILL PATIENT.
Q09	EXTERNAL AUDIT INVESTIGATION SETTLEMENT RECOVERY; DO NOT BILL PATIENT.
Q10	CLAIM PREVIOUSLY ADJUSTED BY EXTERNAL AUDIT.
S01	MEDICARE PART B DEDUCTIBLE IS NOT A CONTRACT BENEFIT.
S02	MEDICARE PART A DEDUCTIBLE ALREADY BILLED FOR THIS BENEFIT PERIOD.
S03	SERVICES/SUPPLIES NOT COVERED BY MEDICARE ARE NOT COVERED BY CONTRACT.
S04	SUPPLEMENTAL PAYMENT MADE BASED ON MAXIMUM ALLOWABLE FEE.
S05	MEDICARE HAS PAID ALLOWED CHARGES IN FULL. NO ADDITIONAL PAYMENT NECESSARY.
S06	PROCEDURE CANNOT BE PROCESSED UNTIL MEDICARE HAS COMPLETED PROCESSING.
S07	CLAIM IS SUBJECT TO YOUR OUT OF COUNTRY DEDUCTIBLE. WHEN MET, THIS BENEFIT IS PAID AT 80%.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
S08	THE PATIENT IS RESPONSIBLE IF THERE IS A BALANCE ON THIS NON-ASSIGNED CHARGE.
S09	PAYMENT WAS MADE TO THE PROVIDER. PATIENT IS NOT RESPONSIBLE FOR BALANCE OF THIS ASSIGNED CHARGE.
S10	CHARGES DISALLOWED BY MEDICARE ARE NOT COVERED.
S11	MAXIMUM AMOUNT PAYABLE FOR THIS CONDITION.
S12	PAYMENT OF CO-INS AND/OR DEDUCTIBLE PD TO CONTRACT BENEFIT. REMAINING BALANCE IS PATIENT RESPONSIBILITY.
S13	ASSIGNED CLAIM - PATIENT IS NOT RESPONSIBLE FOR BALANCE.
S14	THIS MEDICAL SERVICE, ITEM OR SUPPLY IS NOT PATIENT FINANCIAL RESPONSIBILITY.
S15	THIS PLAN IS PRIMARY - SEND EOCP TO MEDICARE FOR PROCESSING.
S16	THIS PLAN IS PRIMARY - SEND EOCP TO MEDICARE FOR PROCESSING.
S17	PATIENT HAS MEDICARE PART A ONLY - BILL PLAN DIRECTLY.
S18	WILL REPROCESS IF MEDICARE LETTER ANSWERED AND CLAIM(S) RESUBMITTED.
S19	MEDICARE CROSS-OVER CLAIM. THIS PLAN IS PRIMARY FOR THIS DATE OF SERVICE. PLEASE REBILL PLAN DIRECTLY.
S20	SUPPLEMENTAL PAYMENT MADE BASED ON REASONABLE SUBMITTED CHARGES.
S21	MEDICARE MUST PROCESS FIRST. IF NO AUTOMATIC CROSSOVER, SUBMIT EXPLANATION OF MEDICARE BENEFITS TO REGENCE
S22	PROCESSED AS SECONDARY TO MEDICARE ON ASSIGNED CLAIM.
S23	PROCESSED AS SECONDARY TO MEDICARE ON UNASSIGNED CLAIM.
S24	PAID OUT OF SAVINGS.
S25	MEDICARE IS PRIMARY. PLEASE SEND THIS EXPLANATION OF BENEFITS TO MEDICARE FOR PROCESSING.
S26	MEDICARE PART A DEDUCTIBLE IS NOT A CONTRACT BENEFIT.
S27	IF YOU HAVE BEEN BILLED OVER 120% OF THE ALLOWED AMOUNT PLEASE CONTACT YOUR LOCAL MEDICARE OFFICE.
S28	IF YOU HAVE BEEN BILLED OVER 115% OF THE ALLOWED AMOUNT PLEASE CONTACT YOUR LOCAL MEDICARE OFFICE.
S29	MEDICARE DENIED AS DUPLICATE. PLAN HAS NO RECORD OF PREVIOUS PAYMENT. SUBMIT ORIGINAL MEDICARE EOMB.
S30	A PORTION OF THIS CHARGE IS APPLIED TO THE MEDICARE PART B DEDUCTIBLE, WHICH IS NOT A CONTRACT BENEFIT.
S31	MEDICARE CROSS REFERENCE NOW IN EFFECT. ONLY SUBMIT HARD COPY CLAIMS IF 4 WEEKS PAST MEDICARE PAID DATE.
S32	REQUIRED REMITTANCE VOUCHER OR EXPLANATION OF MEDICARE BENEFITS NOT RECEIVED WILL REPROCESS WHEN RECEIVED
S34	CHARGE DENIED BY MEDICARE. WE ARE CURRENTLY PROCESSING CHARGES AS PRIMARY.
S35	MEMBER WAIVED MEDICARE PART B - PAYMENT BASED AS SECONDARY PAYOR
S36	MEDICARE HIC NUMBER NEEDED.CALL CUSTOMER SERVICE AT THE NUMBER FOUND ON THE BACK OF YOUR ID CARD
S37	THIS IS A MEDICARE ADVANTAGE TYPE CLAIM. MEDICARE CHARGE LIMITATIONS MAY APPLY.
S38	ADJUSTMENT TO A PREVIOUSLY PROCESSED CLAIM, RESULT OF THE UPDATE OF THE 2006 MEDICARE FEE SCHEDULE.
T01	BILL AUTOMOBILE INSURER. AUTO INSURANCE PRIMARY.
T02	DUE TO ACCIDENTAL INJURY NO-FAULT INSURANCE IS PRIMARY.
T03	SUBROGATION CASE IN PROCESS. PAYMENT MAY BE RECLAIMED.
T04	OCCUPATIONAL INJURY AND/OR ILLNESS NOT COVERED BY CONTRACT.
T05	ACCIDENT REPORT NOT COMPLETED - WILL REPROCESS IF INFORMATION RECEIVED.
T06	THIRD PARTY SUBROGATION SETTLEMENT RECOVERY.
T07	ACCIDENT REPORT NOT COMPLETED. WILL REPROCESS IF INFORMATION RECEIVED.
T10	MORE INFORMATION IS NEEDED REGARDING YOUR ACCIDENT/SUBROGATION CLAIM.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
T11	CLAIM CANNOT BE PROCESSED UNTIL WORKERS COMPENSATION HAS COMPLETED PROCESSING.
T13	SUBROGATION INTEREST NOT REIMBURSED. ALL FUTURE CLAIMS DENIED PENDING REIMBURSEMENT.
T14	PAYMENT HAS BEEN REDUCED DUE TO P.I.P. REIMBURSEMENT.
T15	THE MEDICAL SERVICE INQUIRY FORM WAS NOT COMPLETED. WE WILL REPROCESS IF INFORMATION IS RECEIVED.
T17	PAYMENT HAS BEEN REDUCED DUE TO AUTO INSURANCE PAYMENT.
T18	PAYMENT HAS BEEN REDUCED DUE TO OTHER PARTY LIABILITY PAYMENT.
T19	PAYMENT HAS BEEN REDUCED DUE TO WORKMANS COMPENSATION PAYMENT.
U01	PROCEDURE PRICED BY MEDICAL REVIEW.
U02	CODE/FEE ADJUSTED BY MEDICAL REVIEW.
U03	PROCEDURE NOT ALLOWED FOLLOWING MEDICAL REVIEW.
U04	PLEASE SUBMIT MEDICAL NECESSITY DOCUMENTATION FOR THIS PROCEDURE.
U05	CHARGES NOT ALLOWED FOLLOWING MEDICAL REVIEW.
U06	PLEASE RESUBMIT USING APPROPRIATE PROCEDURE CODE FOR SERVICES OR SUPPLIES RENDERED.
U07	THIS PROCEDURE/SERVICE IS INCONSISTENT WITH THE DIAGNOSIS BILLED.
U09	MAXIMUM ALLOWANCE PAID FOR THIS PROCEDURE.
U10	MAXIMUM ALLOWANCE PAID FOR THIS PROCEDURE.
U11	PLEASE VERIFY THAT BILLED AMT DOES NOT EXCEED PHARMACY OR SUPPLIER CHARGE.
U12	MEDICAL NECESSITY FOR THIS SERVICE OR SUPPLY HAS NOT BEEN ESTABLISHED.
U13	CO-SURGEONS - PRICED BY MEDICAL REVIEW.
U14	CO-SURGERY PROCEDURE PROCESSED AT 60% OF ALLOWABLE.
U15	PROCEDURE REVIEWED BY MEDICAL REVIEW.
U17	PRIOR PLAN APPROVAL NOT OBTAINED AND SERVICES DETERMINED NOT TO BE MEDICALLY NECESSARY.
U18	INDIVIDUAL BENEFITS MANAGEMENT PROGRAM - MAXIMUM ALLOWED FOR THIS PROCEDURE
U20	INVESTIGATIONAL OR EXPERIMENTAL SERVICES AND SUPPLIES ARE NOT COVERED.
U21	PLEASE SUBMIT MEDICAL RECORD AND/OR MEMBER CONSENT FORM TO DETERMINE WHETHER PROCEDURE IS INVESTIGATIONAL
U22	SERVICES DETERMINED NOT TO BE MEDICALLY NECESSARY. PAID ON AN EXCEPTION BASIS.
U23	SEND H&P, ALL PROG NOTES, LAB, DC SUM, MED/IV SHEETS, MD ORDERS, OP REPORTS; TO DETERMINE MEDICAL NEC.
U24	MEDICAL NECESSITY FOR INPATIENT STAY NOT MET PER ESTABLISHED CRITERIA.
U25	MEDICAL NECESSITY FOR INPATIENT STAY NOT MET PER CRITERIA. DETERMINATION MADE AFTER FACILITY REVIEW.
U26	INVESTIGATIONAL SERVICE NOT COVERED-PROVIDER MAY BILL MEMBER ONLY IF CONSENT FORM SIGNED PRIOR TO SERVICE
U27	INVESTIGATIONAL SERVICES NOT COVERED-CONSENT FORM SIGNED BY MEMBER PRIOR TO SERVICE.
U28	DOCUMENTATION DOES NOT SUPPORT UNITS OF SERVICE BILLED.
U29	DOCUMENTATION DOES NOT SUPPORT MODIFIER BILLED, PAYMENT ADJUSTED BY MEDICAL REVIEW.
U30	PROCEDURE CODE SUBJECT TO HCFA NATIONAL UNBUNDLING RULES - PROCEDURE ALLOWED BY MEDICAL REVIEW.
U31	THIS NON-PARTICIPATING PROVIDER HAS AGREED TO WRITE OFF CHARGES ABOVE THE MAXIMUM ALLOWED AMOUNT.
U32	ENTIRE CLAIM DENIED DUE TO INAPPROPRIATE SURGICAL CPT PROCEDURE CODE.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
U33	PLACE OF SERVICE NOT APPROPRIATE FOR SURGICAL PROCEDURE.
U34	PLEASE SUBMIT THE OPERATIVE REPORT FOR THIS PROCEDURE.
U35	PLEASE SUBMIT THE PATHOLOGY REPORT(S) RELATED TO THIS PROCEDURE
U36	PLEASE SUBMIT THE ANESTHESIA RECORD RELATED TO THIS PROCEDURE
U37	PLEASE SUBMIT THE RELATED RADIOLOGY REPORT(S)
U38	PLEASE SUBMIT THE RELATED LABORATORY REPORT(S)
U39	PLEASE SUBMIT NOTES RELATED TO THE EVALUATION AND MANAGEMENT SERVICE BILLED
U40	PLEASE SUBMIT NOTES RELATED TO THE UNUSUAL SERVICE (-22 MODIFIER)
U41	PLEASE SUBMIT REHABILITATION THERAPY NOTES
U42	PLEASE SUBMIT THE ORDERING PHYSICIAN'S MEDICAL DOCUMENTATION FOR THIS PROCEDURE/SERVICE
U43	PLEASE SUBMIT A TREATMENT PLAN RELATED TO THIS PROCEDURE/CONDITION
U44	PROCEDURE BILLED WITH AN UNLISTED CODE - PLEASE SUBMIT A SPECIFIC DESCRIPTION OF THE PROCEDURE
U45	MODIFIER USED IS NOT APPLICABLE TO THIS CODE
U46	THIS PROCEDURE NOT PAYABLE IN THIS PLACE OF SERVICE
U50	SUPPLEMENTAL EDIT-PROCEDURE ALLOWED BY MEDICAL REVIEW
U51	PRICED BY MEDICAL REVIEW.
WA1	CLAIM PROCESSED BASED ON CASE MANAGEMENT AUTHORIZATION.
WA2	HEALTHY OPTIONS APDRG LOW COST OUTLIER PAYMENT
WA4	HO SCREENING FEE PAID ONLY FOR LEVELS 1 & 2.
WA5	SERVICES PREFORMED BY HEARTMASTERS.
WA6	THIRD AND FOURTH FACILITY FEES PAID AT 25% OF MAXIMUM ALLOWANCE.
WA7	PLEASE RESUBMIT MULTIPLE FACILITY FEES FOR THE SAME DATE OF SERVICE ON A SINGLE CLAIM.
WA8	NON-PAR READMISSION WITHIN 48 HOURS OF DISCHARGE FOR THE SAME CONDITION
WB0	PROCEDURE INCLUDED IN A SIMILAR PROCEDURE - CODING BASED ON STANDARDS OF MEDICAL/SURGICAL PRACTICE
WB1	PROCEDURE INCLUDED IN A SIMILAR PROCEDURE - SERVICES ARE PART OF A MEDICAL/SURGICAL PACKAGE.
WB3	CPT PROCEDURE CODE DEFINITION - COMPONENTS OF A COMPREHENSIVE CODE MAY NOT BE BILLED SEPARATELY.
WB4	SEPARATE PROCEDURE MAY NOT BE BILLED IN CONJUNCTION WITH A MORE COMPREHENSIVE PROCEDURE.
WB7	PROCEDURE INCLUDED IN A SIMILAR PROCEDURE - ONLY THE MOST EXTENSIVE PROCEDURE ALLOWED.
WB8	SEQUENTIAL PROCEDURES - ONLY THE MOST EXTENSIVE SERVICE SHOULD BE REPORTED.
WB9	MUTUALLY EXCLUSIVE CODE WHICH CANNOT REASONABLY BE DONE IN THE SAME SETTING AS ANOTHER BILLED PROCEDURE
WC0	PROCEDURE INCLUDED IN A SIMILAR PROCEDURE - LABORATORY PANELS
WC1	PROCEDURE NOT ALLOWED OR INCLUDED IN A SIMILAR PROCEDURE - COLUMN B CODE WITH COLUMN A CODE
WC2	MUTUALLY EXCLUSIVE PROCEDURES ARE ONLY ALLOWED IF DONE DURING SEPARATE OPERATIVE SESSIONS.
WC3	ANESTHESIA INCLUDED IN SURGICAL PROCEDURES.
WC7	PLEASE RESUBMIT WITH DETAILED DESCRIPTIONS OF SERVICES RENDERED
WC8	CPT/HCPCS CODES REQUIRED FOR DRUG SERVICES.
WC9	CPT PROCEDURE CODES REQUIRED FOR X-RAY AND LAB SERVICES.
WD1	THIS SERVICE IS NOT PAYABLE UNDER THIS PROVIDER SPECIALTY.
WD3	PRESCRIPTION REQUIRED FROM REFERRING PROVIDER FOR THIS SERVICE/SUPPLY.
WD4	NEED ACTUAL DISCHARGE DATE TO COMPLETE THE CLAIM FOR PROCESSING.
WD5	NEED NAME OF BODY PART AND WHICH SIDE, RIGHT OR LEFT

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
WD7	HIGH DOLLAR CLAIM - REVIEWED AND APPROVED.
WD8	HIGH DOLLAR CLAIM - REVIEWED AND REJECTED.
WD9	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
WE1	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.
WE2	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER.
WE3	CLAIM/SERVICE DENIED. APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET.
WE4	PAYMENT ADJUSTED BECAUSE 'NEW PATIENT' QUALIFICATIONS WERE NOT MET.
WE5	CLAIM INCORRECTLY SUBMITTED AS BEING PART OF A GLOBAL FEE. PLEASE RESEND WITH NORMAL PRICING.
WE6	USUAL & CUSTOMARY MAXIMUM FOR PROVIDER'S AREA PREVIOUSLY PROCESSED.
WE7	ADMINISTRATIVE SERVICE.NOT SEPARATELY REIMBURSABLE.
WE8	PAID TO PREVAILING CHARGES FROM AREA WHERE SERVICES WERE RENDERED.
WPT	PHARMACY CLAIM NOT SUBMITTED WITHIN REQUIRED TIME LIMITS.
WSF	CHARGES SHOULD BE SUBMITTED TO THE FACILITY FOR REIMBURSEMENT.
WS0	CODE NOT ALLOWED PER SUPPLEMENTAL EDITS.
W01	PRICED TO AUTOMATED LABORATORY CHARGES.
W02	PAID TO MAXIMUM ALLOWANCE.
W03	MAXIMUM ALLOWANCE DETERMINED BY PROVIDER'S MEDICAL BUREAU.
W04	MAXIMUM ALLOWANCE PAID FOR THIS PROCEDURE.
W05	PROCEDURE NOT ALLOWED OR INCLUDED IN SIMILAR PROCEDURE.
W06	PROCEDURE PAID TO LABORATORY.
W07	PROCEDURE PAID TO ASSOCIATE/ATTENDING PHYSICIAN.
W08	OFFICE CALL INCLUDED IN PROCEDURE.
W09	PROCEDURE INCLUDED IN OFFICE CALL.
W1A	DOCUMENTATION DOES NOT REFLECT PROVIDER BILLING.
W10	CLAIM REVIEWED - ORIGINAL AUDIT CORRECT.
W11	INCLUDED IN FLAT FEE ALLOWANCE.
W12	CLAIM NOT SUBMITTED WITHIN REQUIRED TIME LIMITS.
W13	CHARGES NOT ALLOWED WITH BILLED PROCEDURE.
W14	CONTRACTED PURCHASE PRICE OF DURABLE MEDICAL EQUIPMENT HAS BEEN MET.
W15	CHARGE NOT ALLOWED AND/OR LIMITED TO ONE SERVICE PER DAY.
W16	ALLOWED OR REVISED CHARGES FOR ASSISTANT SURGEON REDUCED BY 80%.
W18	ASSISTANT SURGEON'S FEE NOT PAYABLE.
W19	MAXIMUM ALLOWED FOR DIAGNOSTIC PROCEDURES PRIOR TO SURGERY.
W20	ANESTHESIA NOT PAID TO SURGEON.
W21	ALLOWANCE BASED ON CORRECTED CODE.
W22	MULTIPLE PROCEDURES - ONLY MAJOR PROCEDURE IS PAYABLE.
W23	ALLOWED OR REVISED CHARGES FOR MULTIPLE PROCEDURES REDUCED BY 95%.
W24	ALLOWED OR REVISED CHARGES FOR MULTIPLE PROCEDURES REDUCED BY 90%.
W25	ALLOWED OR REVISED CHARGES FOR MULTIPLE PROCEDURES REDUCED BY 85%.
W26	ALLOWED OR REVISED CHARGES FOR MULTIPLE PROCEDURES REDUCED BY 75%.
W27	ALLOWED OR REVISED CHARGES REDUCED BY 50%.
W28	MAXIMUM ALLOWANCE PAID FOR THIS PROCEDURE.
W29	PAID TO MAXIMUM ALLOWABLE FEE.
W30	PAID TO BENEFIT MAXIMUM ALLOWANCE.
W31	CHARGE DISALLOWED BY PROVIDER'S MEDICAL BUREAU.
W32	PRICED TO AUTOMATED LAB CHARGES.
W34	INPATIENT HOSPITAL ADMISSION APPROVAL NOT OBTAINED - PAYMENT REDUCED.
W35	PROCESSED TO PREFERRED PROVIDER PLAN BENEFITS.
W36	MAXIMUM ALLOWANCE PAID TO PRE-NEGOTIATED RATE.
W37	MAXIMUM PRE-NEGOTIATED RATE PREVIOUSLY PAID.
W39	BILLING FOR SERVICES RENDERED BY NON-PARTICIPATING PROVIDER - NOT COVERED.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
W42	PAID TO GLOBAL FEE.
W47	ONLY ONE DISPENSING FEE ALLOWED.
W49	DAY SUPPLY LIMIT EXCEEDED FOR THIS MEDICATION. ADDITIONAL COPAY APPLIED.
W50	PLEASE BILL THESE SERVICES AT COMPLETION OF TREATMENT.
W51	CHARGES INCLUDED IN DRG PAYMENT AMOUNT. PATIENT NOT RESPONSIBLE FOR CHARGE
W53	SERVICE NOT AUTH BY PCP. IF AUTHORIZED RESUBMIT WITH NEW REFERRAL FORM.
W54	MAXIMUM ALREADY PAID FOR THIS EPISODE OF CARE.
W55	CHARGES BILLED FOR SERVICES NOT YET PROVIDED ARE NOT COVERED.
W57	PAID CARD RX ONLY-OVER DISPENSING FEE ALLOWANCE.
W58	DENIED DUE TO BILLING ERROR
W59	CLAIM REVIEWED - ORIGINAL DENIAL CORRECT.
W67	PAID TO PREVAILING CHARGES FROM AREA WHERE SERVICES WERE RENDERED.
W68	MAXIMUM ALLOWABLE FACILITY FEE PAID FOR PROCEDURE.
W69	SECONDARY FACILITY FEE PAID AT 50% OF MAXIMUM ALLOWANCE.
W70	THIS SERVICE BY THIS PROVIDER NOT WITHIN THE SCOPE OF THEIR LICENSE.
W71	INCLUDED IN ROOM AND BOARD ALLOWANCE.
W73	CHARGES HAVE BEEN REDUCED TO THE AMOUNT ALLOWED FOR SURGICAL ASSISTS.
W74	THIS SERVICE IS CONSIDERED AN INTEGRAL PART OF THE PRIMARY SERVICE-NOT ELIGIBLE FOR SEPARATE PAYMENT.
W75	CLAIM NOT SUBMITTED WITHIN REQUIRED TIME LIMITS.
W77	PRESCRIPTION DRUGS HAVE BEEN SUBMITTED TO OUR ADMINISTRATOR FOR PROCESSING.
W82	PLEASE RESUBMIT USING APPROPRIATE PROCEDURE CODE FOR SERVICES OR SUPPLIES RENDERED.
W83	THE PROFESSIONAL CHARGES SHOULD BE INCLUDED IN THE FACILITY BILL. REFER QUESTIONS TO VBH 1-800-892-1411.
W85	THIS PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR REQUIRED MODIFIER IS MISSING.
W86	FACILITY FEE NOT COVERED FOR THIS PROCEDURE.
W87	PROCESSED TO INCENTIVES PLAN BENEFITS.
W88	ALLOWANCE BASED ON CORRECTED CODE. EFFECTIVE 2/1/94, BILL CORRECT CODE TO AVOID DISALLOWANCE OF CHARGES.
W90	A READMISSION WITHIN 48 HOURS OF DISCHARGE FOR THE SAME CONDITION IS PAID AT A SINGLE APDRG RATE.
W91	APDRG PAYMENT INCLUDES DAY-OUTLIER AMOUNTS.
W94	ENTIRE PROVIDER PAYMENT INCLUDED IN NEGOTIATED GLOBAL ARRANGEMENT.
W95	TECHNICAL COMPONENT NOT ALLOWED FOR THIS PROCEDURE.
W97	YOU ARE A SELECTMED HOSPITAL. THERE IS NO PATIENT RESPONSIBILITY.
W98	A READMISSION WITHIN 48 HOURS OF DISCHARGE FOR RELATED CONDITIONS IS PAID TO A PERCENT OF BILLED CHARGES.
W99	A SPECIFIC DX IS REQUIRED FOR LABORATORY TESTING. WILL REPROCESS WHEN RECEIVED.
X01	SUBJECT TO MATERNITY DEDUCTIBLE.
X02	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE.
X03	SUBJECT TO ANNUAL DEDUCTIBLE.
X07	SUBJECT TO DENTAL DEDUCTIBLE.
X09	SUBJECT TO MEDICAL/DENTAL DEDUCTIBLE.
X10	SUBJECT TO SERVICE COPAYMENT/DEDUCTIBLE.
X11	COPAYMENT WAIVED.
X15	PAYMENT REFLECTS \$10 COPAYMENT FOR PREFERRED PHYSICIAN VISIT. PHYSICIAN.
X16	SUBJECT TO EXTENDED-NETWORK ANNUAL DEDUCTIBLE.
X18	SUBJECT TO OUT-OF-NETWORK EMERGENCY ROOM COPAY.
X19	SUBJECT TO IN-NETWORK EMERGENCY ROOM COPAY.
X20	SUBJECT TO NON-MANAGED/NON-NETWORK ANNUAL DEDUCTIBLE.

**Regence BlueShield Message Codes**

<b>Code</b>	<b>Description</b>
X21	SUBJECT TO IN-NETWORK ANNUAL DEDUCTIBLE.
X22	SUBJECT TO QUARTERLY DEDUCTIBLE.
X23	SUBJECT TO ANNUAL BENEFIT SPECIFIC DEDUCTIBLE.
X24	WAIVED ITS SUPPLEMENTAL AMOUNT.
Z01	STOPLOSS MAXIMUM HAS BEEN SATISFIED WITH THIS CLAIM. BALANCE PAID AT 100%.
Z02	FAMILY STOPLOSS HAS BEEN SATISFIED WITH THIS CLAIM. BALANCE PAID AT 100%.
Z03	STOPLOSS MAXIMUM HAS BEEN SATISFIED WITH THIS CLAIM.
Z04	FAMILY STOPLOSS HAS BEEN SATISFIED WITH THIS CLAIM.
Z05	CO-PAYMENT LIMITED PER CONTRACT.
Z06	MANAGED OUT OF POCKET COST REACHED.
Z07	NON-MANAGED OUT OF POCKET COSTS REACHED.
Z08	FAMILY NON-MANAGED OUT OF POCKET COSTS REACHED.
Z09	FAMILY MANAGED OUT OF POCKET COSTS REACHED.