

Remittance Advice Remark Codes Currently Valid Codes– November 1, 2008

M1	X-ray not taken within the past 12 months or near enough to the start of treatment. Start: 1/1/1997
M2	Not paid separately when the patient is an inpatient. Start: 1/1/1997
M3	Equipment is the same or similar to equipment already being used. Start: 1/1/1997
M4	Alert: This is the last monthly installment payment for this durable medical equipment. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed. Start: 1/1/1997
M6	Alert: You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price. Start: 1/1/1997
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen. Start: 1/1/1997
M9	Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
M10	Equipment purchases are limited to the first or the tenth month of medical necessity. Start: 1/1/1997
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code. Start: 1/1/1997
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim. Start: 1/1/1997
M13	Only one initial visit is covered per specialty per medical group. Start: 1/1/1997 Last Modified: 6/30/2007 Note: (Modified 6/30/03)
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection. Start: 1/1/1997
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start: 1/1/1997
M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Reactivated 4/1/04, Modified 11/18/05, 4/1/07)

M17	<p>Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
M18	<p>Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.</p> <p>Start: 1/1/1997 Last Modified: 6/30/2003</p> <p>Note: (Modified 6/30/03)</p>
M19	<p>Missing oxygen certification/re-certification.</p> <p>Start: 1/1/1997 Last Modified: 2/28/2003</p> <p>Note: (Modified 2/28/03) Related to N234</p>
M20	<p>Missing/incomplete/invalid HCPCS.</p> <p>Start: 1/1/1997 Last Modified: 2/28/2003</p> <p>Note: (Modified 2/28/03)</p>
M21	<p>Missing/incomplete/invalid place of residence for this service/item provided in a home.</p> <p>Start: 1/1/1997 Last Modified: 2/28/2003</p> <p>Note: (Modified 2/28/03)</p>
M22	<p>Missing/incomplete/invalid number of miles traveled.</p> <p>Start: 1/1/1997 Last Modified: 2/28/2003</p> <p>Note: (Modified 2/28/03)</p>
M23	<p>Missing invoice.</p> <p>Start: 1/1/1997 Last Modified: 8/1/2005</p> <p>Note: (Modified 8/1/05)</p>
M24	<p>Missing/incomplete/invalid number of doses per vial.</p> <p>Start: 1/1/1997 Last Modified: 2/28/2003</p> <p>Note: (Modified 2/28/03)</p>
M25	<p>The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.</p> <p>Start: 1/1/1997 Last Modified: 11/5/2007</p> <p>Note: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07)</p>
M26	<p>The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.</p> <p>The requirements for refund are in 1824(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.</p> <p>Start: 1/1/1997 Last Modified: 11/5/2007</p> <p>Note: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)</p>
M27	<p>Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.</p> <p>Start: 1/1/1997 Last Modified: 8/1/2007</p> <p>Note: (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)</p>

M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available. Start: 1/1/1997
M29	Missing operative note/report. Start: 1/1/1997 Last Modified: 7/1/2008 Note: (Modified 2/28/03, 7/1/2008) Related to N233
M30	Missing pathology report. Start: 1/1/1997 Last Modified: 8/1/2004 Note: (Modified 8/1/04, 2/28/03) Related to N236
M31	Missing radiology report. Start: 1/1/1997 Last Modified: 8/1/2004 Note: (Modified 8/1/04, 2/28/03) Related to N240
M32	Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase. Start: 1/1/1997
M37	Service not covered when the patient is under age 35. Start: 1/1/1997
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay. Start: 1/1/1997
M39	Alert: The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 2/1/04, 4/1/07)
M40	Claim must be assigned and must be filed by the practitioner's employer. Start: 1/1/1997
M41	We do not pay for this as the patient has no legal obligation to pay for this. Start: 1/1/1997
M42	The medical necessity form must be personally signed by the attending physician. Start: 1/1/1997
M44	Missing/incomplete/invalid condition code. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M45	Missing/incomplete/invalid occurrence code(s). Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04) Related to N299
M46	Missing/incomplete/invalid occurrence span code(s). Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04) Related to N300
M47	Missing/incomplete/invalid internal or document control number. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)

M49	Missing/incomplete/invalid value code(s) or amount(s). Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M50	Missing/incomplete/invalid revenue code(s). Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M51	Missing/incomplete/invalid procedure code(s). Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04) Related to N301
M52	Missing/incomplete/invalid "from" date(s) of service. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M53	Missing/incomplete/invalid days or units of service. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M54	Missing/incomplete/invalid total charges. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug. Start: 1/1/1997
M56	Missing/incomplete/invalid payer identifier. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M59	Missing/incomplete/invalid "to" date(s) of service. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M60	Missing Certificate of Medical Necessity. Start: 1/1/1997 Last Modified: 8/1/2004 Note: (Modified 8/1/04, 6/30/03) Related to N227
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired. Start: 1/1/1997
M62	Missing/incomplete/invalid treatment authorization code. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M64	Missing/incomplete/invalid other diagnosis. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician. Start: 1/1/1997
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items. Start: 1/1/1997
M67	Missing/incomplete/invalid other procedure code(s). Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04) Related to N302

M69	<p>Paid at the regular rate as you did not submit documentation to justify the modified procedure code. Start: 1/1/1997 Last Modified: 2/1/2004 Note: (Modified 2/1/04)</p>
M70	<p>Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item. Start: 1/1/1997 Last Modified: 8/1/2007 Note: (Modified 4/1/2007, 8/1/07)</p>
M71	<p>Total payment reduced due to overlap of tests billed. Start: 1/1/1997</p>
M73	<p>The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Start: 1/1/1997 Last Modified: 8/1/2004 Note: (Modified 8/1/04)</p>
M74	<p>This service does not qualify for a HPSA/Physician Scarcity bonus payment. Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04)</p>
M75	<p>Multiple automated multichannel tests performed on the same day combined for payment. Start: 1/1/1997 Last Modified: 11/5/2007 Note: (Modified 11/5/07)</p>
M76	<p>Missing/incomplete/invalid diagnosis or condition. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)</p>
M77	<p>Missing/incomplete/invalid place of service. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)</p>
M79	<p>Missing/incomplete/invalid charge. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)</p>
M80	<p>Not covered when performed during the same session/date as a previously processed service for the patient. Start: 1/1/1997 Last Modified: 10/31/2002 Note: (Modified 10/31/02)</p>
M81	<p>You are required to code to the highest level of specificity. Start: 1/1/1997 Last Modified: 2/1/2004 Note: (Modified 2/1/04)</p>
M82	<p>Service is not covered when patient is under age 50. Start: 1/1/1997</p>
M83	<p>Service is not covered unless the patient is classified as at high risk. Start: 1/1/1997</p>
M84	<p>Medical code sets used must be the codes in effect at the time of service Start: 1/1/1997 Last Modified: 2/1/2004 Note: (Modified 2/1/04)</p>
M85	<p>Subjected to review of physician evaluation and management services. Start: 1/1/1997</p>
M86	<p>Service denied because payment already made for same/similar procedure within set time frame. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)</p>

M87	Claim/service(s) subjected to CFO-CAP prepayment review. Start: 1/1/1997
M89	Not covered more than once under age 40. Start: 1/1/1997
M90	Not covered more than once in a 12 month period. Start: 1/1/1997
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims. Start: 1/1/1997
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment. Start: 1/1/1997
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin. Start: 1/1/1997
M95	Services subjected to Home Health Initiative medical review/cost report audit. Start: 1/1/1997
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only. Start: 1/1/1997
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility. Start: 1/1/1997
M99	Missing/incomplete/invalid Universal Product Number/Serial Number. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug. Start: 1/1/1997
M102	Service not performed on equipment approved by the FDA for this purpose. Start: 1/1/1997
M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment. Start: 1/1/1997
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service. Start: 1/1/1997
M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin. Start: 1/1/1997
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%. Start: 1/1/1997
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner. Start: 1/1/1997
M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken. Start: 1/1/1997

M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides. Start: 1/1/1997 Last Modified: 11/5/2007 Note: (Modified 11/5/07)
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program. Start: 1/1/1997 Last Modified: 11/5/2007 Note: (Modified 11/5/07)
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. Start: 1/1/1997 Last Modified: 11/5/2007 Note: (Modified 8/1/06, 11/5/07)
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier. Start: 1/1/1997 Last Modified: 11/5/2007 Note: (Modified 11/5/2007)
M116	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project. Start: 1/1/1997 Last Modified: 2/1/2004 Note: (Modified 2/1/04)
M117	Not covered unless submitted via electronic claim. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
M118	Alert: Letter to follow containing further information. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 2/28/03, 4/1/04)
M121	We pay for this service only when performed with a covered cryosurgical ablation. Start: 1/1/1997
M122	Missing/incomplete/invalid level of subluxation. Start: 1/1/1997 Last Modified: 2/28/2006 Note: (Modified 2/28/03)
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M124	Missing indication of whether the patient owns the equipment that requires the part or supply. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N230
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M126	Missing/incomplete/invalid individual lab codes included in the test. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M127	Missing patient medical record for this service. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N237

M129	Missing/incomplete/invalid indicator of x-ray availability for review. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 2/28/03, 6/30/03)
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N231
M131	Missing physician financial relationship form. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N239
M132	Missing pacemaker registration form. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N235
M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test. Start: 1/1/1997
M134	Performed by a facility/supplier in which the provider has a financial interest. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
M135	Missing/incomplete/invalid plan of treatment. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
M137	Part B coinsurance under a demonstration project. Start: 1/1/1997
M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants. Start: 1/1/1997
M139	Denied services exceed the coverage limit for the demonstration. Start: 1/1/1997
M141	Missing physician certified plan of care. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N238
M142	Missing American Diabetes Association Certificate of Recognition. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N226
M143	The provider must update license information with the payer. Start: 1/1/1997 Last Modified: 12/1/2006 Note: (Modified 12/1/06)
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 1/1/1997
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)

MA02	<p>Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 10/31/02, 6/30/03, 8/1/05, 12/29/05, 8/1/06, 4/1/07)</p>
MA04	<p>Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.</p> <p>Start: 1/1/1997</p>
MA07	<p>Alert: The claim information has also been forwarded to Medicaid for review.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA08	<p>Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA09	<p>Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.</p> <p>Start: 1/1/1997</p>
MA10	<p>Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA12	<p>You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).</p> <p>Start: 1/1/1997</p>
MA13	<p>Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA14	<p>Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.</p> <p>Start: 1/1/1997 Last Modified: 8/1/2007</p> <p>Note: (Modified 4/1/07, 8/1/07)</p>
MA15	<p>Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA16	<p>The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.</p> <p>Start: 1/1/1997</p>
MA17	<p>We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.</p> <p>Start: 1/1/1997</p>
MA18	<p>Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA19	<p>Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.</p> <p>Start: 1/1/1997 Last Modified: 4/1/2007</p> <p>Note: (Modified 4/1/07)</p>
MA20	<p>Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.</p> <p>Start: 1/1/1997 Last Modified: 6/30/2003</p> <p>Note: (Modified 6/30/03)</p>

MA21	SSA records indicate mismatch with name and sex. Start: 1/1/1997
MA22	Payment of less than \$1.00 suppressed. Start: 1/1/1997
MA23	Demand bill approved as result of medical review. Start: 1/1/1997
MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
MA25	A patient may not elect to change a hospice provider more than once in a benefit period. Start: 1/1/1997
MA26	Alert: Our records indicate that you were previously informed of this rule. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA30	Missing/incomplete/invalid type of bill. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA32	Missing/incomplete/invalid number of covered days during the billing period. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA33	Missing/incomplete/invalid noncovered days during the billing period. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA35	Missing/incomplete/invalid number of lifetime reserve days. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA36	Missing/incomplete/invalid patient name. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA37	Missing/incomplete/invalid patient's address. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)

MA39	Missing/incomplete/invalid gender. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA40	Missing/incomplete/invalid admission date. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA41	Missing/incomplete/invalid admission type. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA42	Missing/incomplete/invalid admission source. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA43	Missing/incomplete/invalid patient status. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA44	Alert: No appeal rights. Adjudicative decision based on law. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA45	Alert: As previously advised, a portion or all of your payment is being held in a special account. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA46	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation. Start: 1/1/1997
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment. Start: 1/1/1997
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification. Start: 1/1/1997 Last Modified: 2/1/2004 Note: (Modified 2/1/04)
MA54	Physician certification or election consent for hospice care not received timely. Start: 1/1/1997
MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services. Start: 1/1/1997
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount. Start: 1/1/1997
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services. Start: 1/1/1997

MA58	Missing/incomplete/invalid release of information indicator. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA59	Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA60	Missing/incomplete/invalid patient relationship to insured. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA61	Missing/incomplete/invalid social security number or health insurance claim number. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA62	Alert: This is a telephone review decision. Start: 1/1/1997 Last Modified: 8/1/2007 Note: (Modified 4/1/07, 8/1/07)
MA63	Missing/incomplete/invalid principal diagnosis. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers. Start: 1/1/1997
MA65	Missing/incomplete/invalid admitting diagnosis. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA66	Missing/incomplete/invalid principal procedure code. Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04) Related to N303
MA67	Correction to a prior claim. Start: 1/1/1997
MA68	Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA69	Missing/incomplete/invalid remarks. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA70	Missing/incomplete/invalid provider representative signature. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA71	Missing/incomplete/invalid provider representative signature date. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA72	Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)

MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care. Start: 1/1/1997
MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned. Start: 1/1/1997
MA75	Missing/incomplete/invalid patient or authorized representative signature. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03, 2/1/04)
MA77	Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice. Start: 1/1/1997 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
MA79	Billed in excess of interim rate. Start: 1/1/1997
MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project. Start: 1/1/1997
MA81	Missing/incomplete/invalid provider/supplier signature. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA83	Did not indicate whether we are the primary or secondary payer. Start: 1/1/1997 Last Modified: 8/1/2005 Note: (Modified 8/1/05)
MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy. Start: 1/1/1997
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA90	Missing/incomplete/invalid employment status code for the primary insured. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03).
MA91	This determination is the result of the appeal you filed. Start: 1/1/1997
MA92	Missing plan information for other insurance. Start: 1/1/1997 Last Modified: 2/1/2004 Note: (Modified 2/1/04) Related to N245
MA93	Non-PIP (Periodic Interim Payment) claim. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)

MA94	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice. Start: 1/1/1997 Last Modified: 8/1/2005 Note: (Reactivated 4/1/04, Modified 8/1/05)
MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan. Start: 1/1/1997
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number. Start: 1/1/1997 Last Modified: 2/29/2008 Note: (Modified 2/29/08)
MA99	Missing/incomplete/invalid Medigap information. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA100	Missing/incomplete/invalid date of current illness or symptoms Start: 1/1/1997 Last Modified: 3/30/2005 Note: (Modified 2/28/03, 3/30/05)
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
MA103	Hemophilia Add On. Start: 1/1/1997
MA106	PIP (Periodic Interim Payment) claim. Start: 1/1/1997 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
MA107	Paper claim contains more than three separate data items in field 19. Start: 1/1/1997
MA108	Paper claim contains more than one data item in field 23. Start: 1/1/1997
MA109	Claim processed in accordance with ambulatory surgical guidelines. Start: 1/1/1997
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA112	Missing/incomplete/invalid group practice information. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN. Start: 1/1/1997
MA114	Missing/incomplete/invalid information on where the services were furnished. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)

MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA). Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution. Start: 1/1/1997 Note: (Reactivated 4/1/04)
MA117	This claim has been assessed a \$1.00 user fee. Start: 1/1/1997
MA118	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued. Start: 1/1/1997
MA120	Missing/incomplete/invalid CLIA certification number. Start: 1/1/1997 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
MA121	Missing/incomplete/invalid x-ray date. Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04)
MA122	Missing/incomplete/invalid initial treatment date. Start: 1/1/1997 Last Modified: 12/2/2004 Note: (Modified 12/2/04)
MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services. Start: 1/1/1997
MA125	Per legislation governing this program, payment constitutes payment in full. Start: 1/1/1997
MA126	Pancreas transplant not covered unless kidney transplant performed. Start: 10/12/2001
MA128	Missing/incomplete/invalid FDA approval number. Start: 10/12/2001 Last Modified: 3/30/2005 Note: (Modified 2/28/03, 3/30/05)
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. Start: 10/12/2001
MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim. Start: 10/12/2001
MA132	Adjustment to the pre-demonstration rate. Start: 10/12/2001
MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay. Start: 10/12/2001
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides. Start: 10/12/2001
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 2/28/03, 4/1/07)

N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan. Start: 1/1/2000
N3	Missing consent form. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03) Related to N228
N4	Missing/incomplete/invalid prior insurance carrier EOB. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N5	EOB received from previous payer. Claim not on file. Start: 1/1/2000
N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N7	Processing of this claim/service has included consideration under Major Medical provisions. Start: 1/1/2000
N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication. Start: 1/1/2000
N9	Adjustment represents the estimated amount a previous payer may pay. Start: 1/1/2000 Last Modified: 11/18/2005 Note: (Modified 11/18/05)
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
N11	Denial reversed because of medical review. Start: 1/1/2000
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare. Start: 1/1/2000 Last Modified: 8/1/2007 Note: (Modified 8/1/07)
N13	Payment based on professional/technical component modifier(s). Start: 1/1/2000
N15	Services for a newborn must be billed separately. Start: 1/1/2000
N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage. Start: 1/1/2000
N19	Procedure code incidental to primary procedure. Start: 1/1/2000
N20	Service not payable with other service rendered on the same date. Start: 1/1/2000
N21	Alert: Your line item has been separated into multiple lines to expedite handling. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 8/1/05, 4/1/07)
N22	This procedure code was added/changed because it more accurately describes the services rendered. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 10/31/02, 2/28/03)

N23	<p>Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 8/13/01, 4/1/07)</p>
N24	<p>Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)</p>
N25	<p>This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan. Start: 1/1/2000</p>
N26	<p>Missing itemized bill/statement. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 2/28/03, 7/1/2008) Related to N232</p>
N27	<p>Missing/incomplete/invalid treatment number. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)</p>
N28	<p>Consent form requirements not fulfilled. Start: 1/1/2000</p>
N29	<p>Missing documentation/orders/notes/summary/report/chart. Start: 1/1/2000 Last Modified: 8/1/2005 Note: (Modified 2/28/03, 8/1/05) Related to N225</p>
N30	<p>Patient ineligible for this service. Start: 1/1/2000 Last Modified: 6/30/2003 Note: (Modified 6/30/03)</p>
N31	<p>Missing/incomplete/invalid prescribing provider identifier. Start: 1/1/2000 Last Modified: 12/2/2004 Note: (Modified 12/2/04)</p>
N32	<p>Claim must be submitted by the provider who rendered the service. Start: 1/1/2000 Last Modified: 6/30/2003 Note: (Modified 6/30/03)</p>
N33	<p>No record of health check prior to initiation of treatment. Start: 1/1/2000</p>
N34	<p>Incorrect claim form/format for this service. Start: 1/1/2000 Last Modified: 11/18/2005 Note: (Modified 11/18/05)</p>
N35	<p>Program integrity/utilization review decision. Start: 1/1/2000</p>
N36	<p>Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/2000</p>
N37	<p>Missing/incomplete/invalid tooth number/letter. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)</p>
N39	<p>Procedure code is not compatible with tooth number/letter. Start: 1/1/2000</p>
N40	<p>Missing radiology film(s)/image(s). Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 2/1/04, 7/1/08) Related to N242</p>

N42	No record of mental health assessment. Start: 1/1/2000
N43	Bed hold or leave days exceeded. Start: 1/1/2000
N45	Payment based on authorized amount. Start: 1/1/2000
N46	Missing/incomplete/invalid admission hour. Start: 1/1/2000
N47	Claim conflicts with another inpatient stay. Start: 1/1/2000
N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/2000
N49	Court ordered coverage information needs validation. Start: 1/1/2000
N50	Missing/incomplete/invalid discharge information. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N51	Electronic interchange agreement not on file for provider/submitter. Start: 1/1/2000
N52	Patient not enrolled in the billing provider's managed care plan on the date of service. Start: 1/1/2000
N53	Missing/incomplete/invalid point of pick-up address. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/2000
N55	Procedures for billing with group/referring/performing providers were not followed. Start: 1/1/2000
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N57	Missing/incomplete/invalid prescribing date. Start: 1/1/2000 Last Modified: 12/2/2004 Note: (Modified 12/2/04) Related to N304
N58	Missing/incomplete/invalid patient liability amount. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N59	Alert: Please refer to your provider manual for additional program and provider information. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N61	Rebill services on separate claims. Start: 1/1/2000
N62	Inpatient admission spans multiple rate periods. Resubmit separate claims. Start: 1/1/2000

N63	Rebill services on separate claim lines. Start: 1/1/2000
N64	The "from" and "to" dates must be different. Start: 1/1/2000
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim. Start: 1/1/2000
N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days. Start: 1/1/2000
N69	PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies. Start: 1/1/2000 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
N70	Consolidated billing and payment applies. Start: 1/1/2000 Last Modified: 11/5/2007 Note: (Modified 2/28/02, 11/5/07)
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims. Start: 1/1/2000 Last Modified: 6/30/2003 Note: (Modified 2/21/02, 6/30/03)
N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records. Start: 1/1/2000 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month. Start: 1/1/2000
N75	Missing/incomplete/invalid tooth surface information. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N76	Missing/incomplete/invalid number of riders. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N77	Missing/incomplete/invalid designated provider number. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N78	The necessary components of the child and teen checkup (EPSDT) were not completed. Start: 1/1/2000
N79	Service billed is not compatible with patient location information. Start: 1/1/2000

N80	Missing/incomplete/invalid prenatal screening information. Start: 1/1/2000 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N81	Procedure billed is not compatible with tooth surface code. Start: 1/1/2000
N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement. Start: 1/1/2000
N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project. Start: 1/1/2000
N84	Alert: Further installment payments are forthcoming. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 4/1/07, 8/1/07)
N85	Alert: This is the final installment payment. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 4/1/07, 8/1/07)
N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered. Start: 1/1/2000
N87	Home use of biofeedback therapy is not covered. Start: 1/1/2000
N88	Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N89	Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice. Start: 1/1/2000 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N90	Covered only when performed by the attending physician. Start: 1/1/2000
N91	Services not included in the appeal review. Start: 1/1/2000
N92	This facility is not certified for digital mammography. Start: 1/1/2000
N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim. Start: 1/1/2000
N94	Claim/Service denied because a more specific taxonomy code is required for adjudication. Start: 1/1/2000
N95	This provider type/provider specialty may not bill this service. Start: 7/31/2001 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur. Start: 8/24/2001

N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded. Start: 8/24/2001
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries. Start: 8/24/2001
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated. Start: 8/24/2001
N100	PPS (Prospect Payment System) code corrected during adjudication. Start: 9/14/2001 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely. Start: 10/31/2001
N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt. Start: 10/31/2001 Last Modified: 6/30/2003 Note: (Modified 6/30/03)
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov . Start: 1/29/2002 Last Modified: 10/31/2002 Note: (Modified 10/31/02)
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing. Start: 1/29/2002
N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service. Start: 1/31/2002
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services. Start: 1/31/2002
N108	Missing/incomplete/invalid upgrade information. Start: 1/31/2002 Last Modified: 2/28/2003 Note: (Modified 2/28/03)
N109	This claim was chosen for complex review and was denied after reviewing the medical records. Start: 2/28/2002
N110	This facility is not certified for film mammography. Start: 2/28/2002
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated. Start: 2/28/2002
N112	This claim is excluded from your electronic remittance advice. Start: 2/28/2002
N113	Only one initial visit is covered per physician, group practice or provider. Start: 4/16/2002 Last Modified: 6/30/2003 Note: (Modified 6/30/03)

N114	<p>During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.</p> <p>Start: 5/30/2002</p>
N115	<p>This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP/LCD.</p> <p>Start: 5/30/2002 Last Modified: 4/1/2004</p> <p>Note: (Modified 4/1/04)</p>
N116	<p>This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.</p> <p>Start: 6/30/2002</p>
N117	<p>This service is paid only once in a patient's lifetime.</p> <p>Start: 7/30/2002 Last Modified: 6/30/2003</p> <p>Note: (Modified 6/30/03)</p>
N118	<p>This service is not paid if billed more than once every 28 days.</p> <p>Start: 7/30/2002</p>
N119	<p>This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days.</p> <p>Start: 7/30/2002 Last Modified: 6/30/2003</p> <p>Note: (Modified 6/30/03)</p>
N120	<p>Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.</p> <p>Start: 8/9/2002 Last Modified: 6/30/2003</p> <p>Note: (Modified 6/30/03)</p>
N121	<p>Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.</p> <p>Start: 9/9/2002 Last Modified: 8/1/2004</p> <p>Note: (Modified 8/1/04, 6/30/03)</p>
N122	<p>Add-on code cannot be billed by itself.</p> <p>Start: 9/12/2002 Last Modified: 8/1/2005</p> <p>Note: (Modified 8/1/05)</p>
N123	<p>This is a split service and represents a portion of the units from the originally submitted service.</p> <p>Start: 9/24/2002</p>
N124	<p>Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.</p> <p>Start: 9/26/2002</p>
N125	<p>Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.</p> <p>The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.</p> <p>Start: 9/26/2002 Last Modified: 8/1/2005</p> <p>Note: (Modified 8/1/05. Also refer to N356)</p>

N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported. Start: 10/17/2002
N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them. Start: 10/31/2007 Last Modified: 8/1/2004 Note: (Modified 8/1/04)
N128	This amount represents the prior to coverage portion of the allowance. Start: 10/31/2002
N129	Not eligible due to the patient's age. Start: 10/31/2002 Last Modified: 8/1/2007 Note: (Modified 8/1/07)
N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service. Start: 10/31/2002 Last Modified: 7/1/2008 Note: (Modified 4/1/07, 7/1/08)
N131	Total payments under multiple contracts cannot exceed the allowance for this service. Start: 10/31/2002
N132	Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N133	Alert: Services for predetermination and services requesting payment are being processed separately. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N134	Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N135	Record fees are the patient's responsibility and limited to the specified co-payment. Start: 10/31/2002
N136	Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N137	Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 8/1/04, 2/28/03, 4/1/07)
N138	Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N139	Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)

N140	<p>Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.</p> <p>Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)</p>
N141	<p>The patient was not residing in a long-term care facility during all or part of the service dates billed.</p> <p>Start: 10/31/2002</p>
N142	<p>The original claim was denied. Resubmit a new claim, not a replacement claim.</p> <p>Start: 10/31/2002</p>
N143	<p>The patient was not in a hospice program during all or part of the service dates billed.</p> <p>Start: 10/31/2002</p>
N144	<p>The rate changed during the dates of service billed.</p> <p>Start: 10/31/2002</p>
N146	<p>Missing screening document.</p> <p>Start: 10/31/2002 Last Modified: 8/1/2004 Note: (Modified 8/1/04) Related to N243</p>
N147	<p>Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.</p> <p>Start: 10/31/2002</p>
N148	<p>Missing/incomplete/invalid date of last menstrual period.</p> <p>Start: 10/31/2002</p>
N149	<p>Rebill all applicable services on a single claim.</p> <p>Start: 10/31/2002</p>
N150	<p>Missing/incomplete/invalid model number.</p> <p>Start: 10/31/2002</p>
N151	<p>Telephone contact services will not be paid until the face-to-face contact requirement has been met.</p> <p>Start: 10/31/2002</p>
N152	<p>Missing/incomplete/invalid replacement claim information.</p> <p>Start: 10/31/2002</p>
N153	<p>Missing/incomplete/invalid room and board rate.</p> <p>Start: 10/31/2002</p>
N154	<p>Alert: This payment was delayed for correction of provider's mailing address.</p> <p>Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)</p>
N155	<p>Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.</p> <p>Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)</p>
N156	<p>Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.</p> <p>Start: 10/31/2002 Last Modified: 4/1/2007 Note: (Modified 4/1/07)</p>
N157	<p>Transportation to/from this destination is not covered.</p> <p>Start: 2/28/2003 Last Modified: 2/1/2004 Note: (Modified 2/1/04)</p>
N158	<p>Transportation in a vehicle other than an ambulance is not covered.</p> <p>Start: 2/28/2003</p>

N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. Start: 2/28/2003
N160	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service. Start: 2/28/2003 Last Modified: 2/1/2004 Note: (Modified 2/1/04)
N161	This drug/service/supply is covered only when the associated service is covered. Start: 2/28/2003
N162	Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future. Start: 2/28/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N163	Medical record does not support code billed per the code definition. Start: 2/28/2003
N167	Charges exceed the post-transplant coverage limit. Start: 2/28/2003
N170	A new/revised/renewed certificate of medical necessity is needed. Start: 2/28/2003
N171	Payment for repair or replacement is not covered or has exceeded the purchase price. Start: 2/28/2003
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item. Start: 2/28/2003
N173	No qualifying hospital stay dates were provided for this episode of care. Start: 2/28/2003
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'. Start: 2/28/2003
N175	Missing review organization approval. Start: 2/28/2003 Last Modified: 2/29/2008 Note: (Modified 8/1/04, 2/29/08) Related to N241
N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service. Start: 2/28/2003
N177	Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made. Start: 2/28/2003 Last Modified: 4/1/2007 Note: (Modified 6/30/03, 4/1/07)
N178	Missing pre-operative photos or visual field results. Start: 2/28/2003 Last Modified: 8/1/2004 Note: (Modified 8/1/04) Related to N244
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information. Start: 2/28/2003
N180	This item or service does not meet the criteria for the category under which it was billed. Start: 2/28/2003
N181	Additional information is required from another provider involved in this service. Start: 2/28/2003 Last Modified: 12/1/2006 Note: (Modified 12/1/06)

N182	This claim/service must be billed according to the schedule for this plan. Start: 2/28/2003
N183	Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits. Start: 2/28/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N184	Rebill technical and professional components separately. Start: 2/28/2003
N185	Alert: Do not resubmit this claim/service. Start: 2/28/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance. Start: 2/28/2003
N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. Start: 2/28/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N188	The approved level of care does not match the procedure code submitted. Start: 2/28/2003
N189	Alert: This service has been paid as a one-time exception to the plan's benefit restrictions. Start: 2/28/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N190	Missing contract indicator. Start: 2/28/2003 Last Modified: 8/1/2004 Note: (Modified 8/1/04) Related to N229
N191	The provider must update insurance information directly with payer. Start: 2/28/2003
N192	Patient is a Medicaid/Qualified Medicare Beneficiary. Start: 2/28/2003
N193	Specific federal/state/local program may cover this service through another payer. Start: 2/28/2003
N194	Technical component not paid if provider does not own the equipment used. Start: 2/25/2003
N195	The technical component must be billed separately. Start: 2/25/2003
N196	Alert: Patient eligible to apply for other coverage which may be primary. Start: 2/25/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N197	The subscriber must update insurance information directly with payer. Start: 2/25/2003
N198	Rendering provider must be affiliated with the pay-to provider. Start: 2/25/2003
N199	Additional payment/recoupment approved based on payer-initiated review/audit. Start: 2/25/2003 Last Modified: 8/1/2006 Note: (Modified 8/1/06)

N200	The professional component must be billed separately. Start: 2/25/2003
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents. Start: 2/25/2003
N202	Alert: Additional information/explanation will be sent separately Start: 6/30/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N203	Missing/incomplete/invalid anesthesia time/units Start: 6/30/2003
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months Start: 6/30/2003
N205	Information provided was illegible Start: 6/30/2003
N206	The supporting documentation does not match the claim Start: 6/30/2003
N207	Missing/incomplete/invalid weight. Start: 6/30/2003 Last Modified: 11/18/2005 Note: (Modified 11/18/05)
N208	Missing/incomplete/invalid DRG code Start: 6/30/2003
N209	Missing/incomplete/invalid taxpayer identification number (TIN). Start: 6/30/2003 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N210	Alert: You may appeal this decision Start: 6/30/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N211	Alert: You may not appeal this decision Start: 6/30/2003 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N212	Charges processed under a Point of Service benefit Start: 2/1/2004
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information Start: 4/1/2004
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s) Start: 4/1/2004
N215	Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination. Start: 4/1/2004 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N216	Patient is not enrolled in this portion of our benefit package Start: 4/1/2004
N217	We pay only one site of service per provider per claim Start: 8/1/2004

N218	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual. Start: 8/1/2004
N219	Payment based on previous payer's allowed amount. Start: 8/1/2004
N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute. Start: 8/1/2004 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N221	Missing Admitting History and Physical report. Start: 8/1/2004
N222	Incomplete/invalid Admitting History and Physical report. Start: 8/1/2004
N223	Missing documentation of benefit to the patient during initial treatment period. Start: 8/1/2004
N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period. Start: 8/1/2004
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart. Start: 8/1/2004 Last Modified: 8/1/2005 Note: (Modified 8/1/05)
N226	Incomplete/invalid American Diabetes Association Certificate of Recognition. Start: 8/1/2004
N227	Incomplete/invalid Certificate of Medical Necessity. Start: 8/1/2004
N228	Incomplete/invalid consent form. Start: 8/1/2004
N229	Incomplete/invalid contract indicator. Start: 8/1/2004
N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply. Start: 8/1/2004
N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used. Start: 8/1/2004
N232	Incomplete/invalid itemized bill/statement. Start: 8/1/2004 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N233	Incomplete/invalid operative note/report. Start: 8/1/2004 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N234	Incomplete/invalid oxygen certification/re-certification. Start: 8/1/2004
N235	Incomplete/invalid pacemaker registration form. Start: 8/1/2004
N236	Incomplete/invalid pathology report. Start: 8/1/2004
N237	Incomplete/invalid patient medical record for this service. Start: 8/1/2004

N238	Incomplete/invalid physician certified plan of care Start: 8/1/2004
N239	Incomplete/invalid physician financial relationship form. Start: 8/1/2004
N240	Incomplete/invalid radiology report. Start: 8/1/2004
N241	Incomplete/invalid review organization approval. Start: 8/1/2004 Last Modified: 2/29/2008 Note: (Modified 2/29/08)
N242	Incomplete/invalid radiology film(s)/image(s). Start: 8/1/2004 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N243	Incomplete/invalid/not approved screening document. Start: 8/1/2004
N244	Incomplete/invalid pre-operative photos/visual field results. Start: 8/1/2004
N245	Incomplete/invalid plan information for other insurance Start: 8/1/2004
N246	State regulated patient payment limitations apply to this service. Start: 12/2/2004
N247	Missing/incomplete/invalid assistant surgeon taxonomy. Start: 12/2/2004
N248	Missing/incomplete/invalid assistant surgeon name. Start: 12/2/2004
N249	Missing/incomplete/invalid assistant surgeon primary identifier. Start: 12/2/2004
N250	Missing/incomplete/invalid assistant surgeon secondary identifier. Start: 12/2/2004
N251	Missing/incomplete/invalid attending provider taxonomy. Start: 12/2/2004
N252	Missing/incomplete/invalid attending provider name. Start: 12/2/2004
N253	Missing/incomplete/invalid attending provider primary identifier. Start: 12/2/2004
N254	Missing/incomplete/invalid attending provider secondary identifier. Start: 12/2/2004
N255	Missing/incomplete/invalid billing provider taxonomy. Start: 12/2/2004
N256	Missing/incomplete/invalid billing provider/supplier name. Start: 12/2/2004
N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Start: 12/2/2004
N258	Missing/incomplete/invalid billing provider/supplier address. Start: 12/2/2004

N259	Missing/incomplete/invalid billing provider/supplier secondary identifier. Start: 12/2/2004
N260	Missing/incomplete/invalid billing provider/supplier contact information. Start: 12/2/2004
N261	Missing/incomplete/invalid operating provider name. Start: 12/2/2004
N262	Missing/incomplete/invalid operating provider primary identifier. Start: 12/2/2004
N263	Missing/incomplete/invalid operating provider secondary identifier. Start: 12/2/2004
N264	Missing/incomplete/invalid ordering provider name. Start: 12/2/2004
N265	Missing/incomplete/invalid ordering provider primary identifier. Start: 12/2/2004
N266	Missing/incomplete/invalid ordering provider address. Start: 12/2/2004
N267	Missing/incomplete/invalid ordering provider secondary identifier. Start: 12/2/2004
N268	Missing/incomplete/invalid ordering provider contact information. Start: 12/2/2004
N269	Missing/incomplete/invalid other provider name. Start: 12/2/2004
N270	Missing/incomplete/invalid other provider primary identifier. Start: 12/2/2004
N271	Missing/incomplete/invalid other provider secondary identifier. Start: 12/2/2004
N272	Missing/incomplete/invalid other payer attending provider identifier. Start: 12/2/2004
N273	Missing/incomplete/invalid other payer operating provider identifier. Start: 12/2/2004
N274	Missing/incomplete/invalid other payer other provider identifier. Start: 12/2/2004
N275	Missing/incomplete/invalid other payer purchased service provider identifier. Start: 12/2/2004
N276	Missing/incomplete/invalid other payer referring provider identifier. Start: 12/2/2004
N277	Missing/incomplete/invalid other payer rendering provider identifier. Start: 12/2/2004
N278	Missing/incomplete/invalid other payer service facility provider identifier. Start: 12/2/2004
N279	Missing/incomplete/invalid pay-to provider name. Start: 12/2/2004
N280	Missing/incomplete/invalid pay-to provider primary identifier. Start: 12/2/2004

N281	Missing/incomplete/invalid pay-to provider address. Start: 12/2/2004
N282	Missing/incomplete/invalid pay-to provider secondary identifier. Start: 12/2/2004
N283	Missing/incomplete/invalid purchased service provider identifier. Start: 12/2/2004
N284	Missing/incomplete/invalid referring provider taxonomy. Start: 12/2/2004
N285	Missing/incomplete/invalid referring provider name. Start: 12/2/2004
N286	Missing/incomplete/invalid referring provider primary identifier. Start: 12/2/2004
N287	Missing/incomplete/invalid referring provider secondary identifier. Start: 12/2/2004
N288	Missing/incomplete/invalid rendering provider taxonomy. Start: 12/2/2004
N289	Missing/incomplete/invalid rendering provider name. Start: 12/2/2004
N290	Missing/incomplete/invalid rendering provider primary identifier. Start: 12/2/2004
N291	Missing/incomplete/invalid rendering provider secondary identifier. Start: 12/2/2004
N292	Missing/incomplete/invalid service facility name. Start: 12/2/2004
N293	Missing/incomplete/invalid service facility primary identifier. Start: 12/2/2004
N294	Missing/incomplete/invalid service facility primary address. Start: 12/2/2004
N295	Missing/incomplete/invalid service facility secondary identifier. Start: 12/2/2004
N296	Missing/incomplete/invalid supervising provider name. Start: 12/2/2004
N297	Missing/incomplete/invalid supervising provider primary identifier. Start: 12/2/2004
N298	Missing/incomplete/invalid supervising provider secondary identifier. Start: 12/2/2004
N299	Missing/incomplete/invalid occurrence date(s). Start: 12/2/2004
N300	Missing/incomplete/invalid occurrence span date(s). Start: 12/2/2004
N301	Missing/incomplete/invalid procedure date(s). Start: 12/2/2004
N302	Missing/incomplete/invalid other procedure date(s). Start: 12/2/2004

N303	Missing/incomplete/invalid principal procedure date. Start: 12/2/2004
N304	Missing/incomplete/invalid dispensed date. Start: 12/2/2004
N305	Missing/incomplete/invalid accident date. Start: 12/2/2004
N306	Missing/incomplete/invalid acute manifestation date. Start: 12/2/2004
N307	Missing/incomplete/invalid adjudication or payment date. Start: 12/2/2004
N308	Missing/incomplete/invalid appliance placement date. Start: 12/2/2004
N309	Missing/incomplete/invalid assessment date. Start: 12/2/2004
N310	Missing/incomplete/invalid assumed or relinquished care date. Start: 12/2/2004
N311	Missing/incomplete/invalid authorized to return to work date. Start: 12/2/2004
N312	Missing/incomplete/invalid begin therapy date. Start: 12/2/2004
N313	Missing/incomplete/invalid certification revision date. Start: 12/2/2004
N314	Missing/incomplete/invalid diagnosis date. Start: 12/2/2004
N315	Missing/incomplete/invalid disability from date. Start: 12/2/2004
N316	Missing/incomplete/invalid disability to date. Start: 12/2/2004
N317	Missing/incomplete/invalid discharge hour. Start: 12/2/2004
N318	Missing/incomplete/invalid discharge or end of care date. Start: 12/2/2004
N319	Missing/incomplete/invalid hearing or vision prescription date. Start: 12/2/2004
N320	Missing/incomplete/invalid Home Health Certification Period. Start: 12/2/2004
N321	Missing/incomplete/invalid last admission period. Start: 12/2/2004
N322	Missing/incomplete/invalid last certification date. Start: 12/2/2004
N323	Missing/incomplete/invalid last contact date. Start: 12/2/2004
N324	Missing/incomplete/invalid last seen/visit date. Start: 12/2/2004

N325	Missing/incomplete/invalid last worked date. Start: 12/2/2004
N326	Missing/incomplete/invalid last x-ray date. Start: 12/2/2004
N327	Missing/incomplete/invalid other insured birth date. Start: 12/2/2004
N328	Missing/incomplete/invalid Oxygen Saturation Test date. Start: 12/2/2004
N329	Missing/incomplete/invalid patient birth date. Start: 12/2/2004
N330	Missing/incomplete/invalid patient death date. Start: 12/2/2004
N331	Missing/incomplete/invalid physician order date. Start: 12/2/2004
N332	Missing/incomplete/invalid prior hospital discharge date. Start: 12/2/2004
N333	Missing/incomplete/invalid prior placement date. Start: 12/2/2004
N334	Missing/incomplete/invalid re-evaluation date Start: 12/2/2004
N335	Missing/incomplete/invalid referral date. Start: 12/2/2004
N336	Missing/incomplete/invalid replacement date. Start: 12/2/2004
N337	Missing/incomplete/invalid secondary diagnosis date. Start: 12/2/2004
N338	Missing/incomplete/invalid shipped date. Start: 12/2/2004
N339	Missing/incomplete/invalid similar illness or symptom date. Start: 12/2/2004
N340	Missing/incomplete/invalid subscriber birth date. Start: 12/2/2004
N341	Missing/incomplete/invalid surgery date. Start: 12/2/2004
N342	Missing/incomplete/invalid test performed date. Start: 12/2/2004
N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date. Start: 12/2/2004
N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date. Start: 12/2/2004
N345	Date range not valid with units submitted. Start: 3/30/2005
N346	Missing/incomplete/invalid oral cavity designation code. Start: 3/30/2005

N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer. Start: 3/30/2005
N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier. Start: 8/1/2005
N349	The administration method and drug must be reported to adjudicate this service. Start: 8/1/2005
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. Start: 8/1/2005 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N351	Service date outside of the approved treatment plan service dates. Start: 8/1/2005
N352	Alert: There are no scheduled payments for this service. Submit a claim for each patient visit. Start: 8/1/2005 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N353	Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim. Start: 8/1/2005 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N354	Incomplete/invalid invoice Start: 8/1/2005
N355	Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days Start: 8/1/2005 Last Modified: 4/1/2007 Note: (Modified 11/18/05, Modified 4/1/07)
N356	This service is not covered when performed with, or subsequent to, a non-covered service. Start: 8/1/2005
N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met. Start: 11/18/2005
N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. Start: 11/18/2005 Last Modified: 4/1/2007 Note: (Modified 4/1/07)

N359	Missing/incomplete/invalid height. Start: 11/18/2005
N360	Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim. Start: 11/18/2005 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N362	The number of Days or Units of Service exceeds our acceptable maximum. Start: 11/18/2005
N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination. Start: 11/18/2005 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N364	Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts. Start: 11/18/2005 Last Modified: 4/1/2007 Note: (Modified 4/1/07)
N365	This procedure code is not payable. It is for reporting/information purposes only. Start: 4/1/2006
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice. Start: 4/1/2006
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account. Start: 4/1/2006 Last Modified: 7/1/2008 Note: (Modified 4/1/07, 11/5/07, 7/1/08)
N368	You must appeal the determination of the previously adjudicated claim. Start: 4/1/2006
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation. Start: 4/1/2006
N370	Billing exceeds the rental months covered/approved by the payer. Start: 8/1/2006
N371	Alert: title of this equipment must be transferred to the patient. Start: 8/1/2006
N372	Only reasonable and necessary maintenance/service charges are covered. Start: 8/1/2006
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. Start: 12/1/2006
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. Start: 12/1/2006
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. Start: 12/1/2006
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. Start: 12/1/2006
N377	Payment based on a processed replacement claim. Start: 12/1/2006 Last Modified: 11/5/2007 Note: (Modified 11/5/07)

N378	Missing/incomplete/invalid prescription quantity. Start: 12/1/2006
N379	Claim level information does not match line level information. Start: 12/1/2006
N380	The original claim has been processed, submit a corrected claim. Start: 4/1/2007
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges. Start: 4/1/2007
N382	Missing/incomplete/invalid patient identifier. Start: 4/1/2007
N383	Services deemed cosmetic are not covered Start: 4/1/2007
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure. Start: 4/1/2007
N385	Notification of admission was not timely according to published plan procedures. Start: 4/1/2007 Last Modified: 11/5/2007 Note: (Modified 11/5/07)
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp . If you do not have web access, you may contact the contractor to request a copy of the NCD. Start: 4/1/2007
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 4/1/2007
N388	Missing/incomplete/invalid prescription number Start: 8/1/2007
N389	Duplicate prescription number submitted. Start: 8/1/2007
N390	This service/report cannot be billed separately. Start: 8/1/2007 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N391	Missing emergency department records. Start: 8/1/2007
N392	Incomplete/invalid emergency department records. Start: 8/1/2007
N393	Missing progress notes/report. Start: 8/1/2007 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N394	Incomplete/invalid progress notes/report. Start: 8/1/2007 Last Modified: 7/1/2008 Note: (Modified 7/1/08)
N395	Missing laboratory report. Start: 8/1/2007
N396	Incomplete/invalid laboratory report. Start: 8/1/2007

N397	Benefits are not available for incomplete service(s)/undelivered item(s). Start: 8/1/2007
N398	Missing elective consent form. Start: 8/1/2007
N399	Incomplete/invalid elective consent form. Start: 8/1/2007
N400	Alert: Electronically enabled providers should submit claims electronically. Start: 8/1/2007
N401	Missing periodontal charting. Start: 8/1/2007
N402	Incomplete/invalid periodontal charting. Start: 8/1/2007
N403	Missing facility certification. Start: 8/1/2007
N404	Incomplete/invalid facility certification. Start: 8/1/2007
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. Start: 8/1/2007
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. Start: 8/1/2007
N407	You are not an approved submitter for this transmission format. Start: 8/1/2007
N408	This payer does not cover deductibles assessed by a previous payer. Start: 8/1/2007
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. Start: 8/1/2007
N410	This is not covered unless the prescription changes. Start: 8/1/2007
N418	Misrouted claim. See the payer's claim submission instructions. Start: 8/1/2007
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. Start: 8/1/2007
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. Start: 8/1/2007
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision. Start: 8/1/2007 Last Modified: 5/8/2008 Note: (Modified 2/29/08, typo fixed 5/8/08)
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. Start: 8/1/2007 Last Modified: 5/8/2008 Note: (Typo fixed 5/8/08)
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. Start: 8/1/2007
N424	Patient does not reside in the geographic area required for this type of payment. Start: 8/1/2007

N425	Statutorily excluded service(s). Start: 8/1/2007
N426	No coverage when self-administered. Start: 8/1/2007
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. Start: 8/1/2007
N428	Service/procedure not covered when performed in this place of service. Start: 8/1/2007
N429	This is not covered since it is considered routine. Start: 8/1/2007
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007
N431	Service is not covered with this procedure. Start: 11/5/2007
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007
N433	Resubmit this claim using only your National Provider Identifier (NPI) Start: 2/29/2008
N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 7/1/2008
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008
N438	This jurisdiction only accepts paper claims Start: 7/1/2008
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008
N441	This missed appointment is not covered. Start: 7/1/2008
N442	Payment based on an alternate fee schedule. Start: 7/1/2008
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. Start: 7/1/2008
N445	Missing document for actual cost or paid amount. Start: 7/1/2008
N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008

N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement Start: 7/1/2008
N449	Payment based on a comparable drug/service/supply. Start: 7/1/2008
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008
N451	Missing Admission Summary Report. Start: 7/1/2008
N452	Incomplete/invalid Admission Summary Report. Start: 7/1/2008
N453	Missing Consultation Report. Start: 7/1/2008
N454	Incomplete/invalid Consultation Report. Start: 7/1/2008
N455	Missing Physician Order. Start: 7/1/2008
N456	Incomplete/invalid Physician Order. Start: 7/1/2008
N457	Missing Diagnostic Report. Start: 7/1/2008
N458	Incomplete/invalid Diagnostic Report. Start: 7/1/2008
N459	Missing Discharge Summary. Start: 7/1/2008
N460	Incomplete/invalid Discharge Summary. Start: 7/1/2008
N461	Missing Nursing Notes. Start: 7/1/2008
N462	Incomplete/invalid Nursing Notes. Start: 7/1/2008
N463	Missing support data for claim. Start: 7/1/2008
N464	Incomplete/invalid support data for claim. Start: 7/1/2008
N465	Missing Physical Therapy Notes/Report. Start: 7/1/2008
N466	Incomplete/invalid Physical Therapy Notes/Report. Start: 7/1/2008
N467	Missing Report of Tests and Analysis Report. Start: 7/1/2008
N468	Incomplete/invalid Report of Tests and Analysis Report. Start: 7/1/2008

N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008
N471	Missing/incomplete/invalid HIPPS Rate Code. Start: 7/1/2008
N472	Payment for this service has been issued to another provider. Start: 7/1/2008
N473	Missing certification. Start: 7/1/2008
N474	Incomplete/invalid certification Start: 7/1/2008
N475	Missing completed referral form. Start: 7/1/2008
N476	Incomplete/invalid completed referral form Start: 7/1/2008
N477	Missing Dental Models. Start: 7/1/2008
N478	Incomplete/invalid Dental Models Start: 7/1/2008
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008
N481	Missing Models. Start: 7/1/2008
N482	Incomplete/invalid Models Start: 7/1/2008
N483	Missing Periodontal Charts. Start: 7/1/2008
N484	Incomplete/invalid Periodontal Charts Start: 7/1/2008
N485	Missing Physical Therapy Certification. Start: 7/1/2008
N486	Incomplete/invalid Physical Therapy Certification. Start: 7/1/2008
N487	Missing Prosthetics or Orthotics Certification. Start: 7/1/2008
N488	Incomplete/invalid Prosthetics or Orthotics Certification Start: 7/1/2008
N489	Missing referral form. Start: 7/1/2008
N490	Incomplete/invalid referral form Start: 7/1/2008

N491	Missing/Incomplete/Invalid Exclusionary Rider Condition. Start: 7/1/2008
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008
N493	Missing Doctor First Report of Injury. Start: 7/1/2008
N494	Incomplete/invalid Doctor First Report of Injury. Start: 7/1/2008
N495	Missing Supplemental Medical Report. Start: 7/1/2008
N496	Incomplete/invalid Supplemental Medical Report. Start: 7/1/2008
N497	Missing Medical Permanent Impairment or Disability Report. Start: 7/1/2008
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report. Start: 7/1/2008
N499	Missing Medical Legal Report. Start: 7/1/2008
N500	Incomplete/invalid Medical Legal Report. Start: 7/1/2008
N501	Missing Vocational Report. Start: 7/1/2008
N502	Incomplete/invalid Vocational Report. Start: 7/1/2008
N503	Missing Work Status Report. Start: 7/1/2008
N504	Incomplete/invalid Work Status Report. Start: 7/1/2008
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time. Start: 11/1/2008
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment. Start: 11/1/2008
N507	Plan distance requirements have not been met. Start: 11/1/2008
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions. Start: 11/1/2008
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing. Start: 11/1/2008

N510	<p>Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.</p> <p>Start: 11/1/2008</p>
N511	<p>Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.</p> <p>Start: 11/1/2008</p>
N512	<p>Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.</p> <p>Start: 11/1/2008</p>
N513	<p>Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.</p> <p>Start: 11/1/2008</p>
N514	<p>Consult plan benefit documents/guidelines for information about restrictions for this service.</p> <p>Start: 11/1/2008</p>
N515	<p>Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.</p> <p>Start: 11/1/2008</p>