carecentrix

Document intent:

This document describes the reasons and codes that contracted providers may receive when a claim is rejeted.

CareCentrix Claim Rejection Code Guide

REJECTION CODE	CATEGORY CODE DESCRIPTION	STATUS CODE DESCRIPTION	ENTITY CODE DESCRIPTION	CARECENTRIX EXPLANATION	PROVIDER REMEDIATION STEPS
A1:19	The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.	Acknowledges receipt of claim/encounter.		The Health Plan has acknowledged receipt of the claim however no final determination has been applied at this time.	No action is necessary, please allow time for adjudication to finalize.
A1:20	The claim/encounter has been accepted into the adjudication system.	Accepted for processing.		Health Plan acknowledges receipt of the claim however the claim has not been finalized as of yet. Please allow time for claim to finalize.	No action is necessary, please allow time for adjudication to finalize.
A2:20	The claim/encounter has been accepted into the adjudication system.	Accepted for processing.		CareCentrix acknowledges receipt of the claim however the claim has not been finalized as of yet. Please allow time for claim to finalize.	No action is necessary, please allow time for adjudication to finalize.
A2:570	The claim/encounter has been accepted into the adjudication system.	Free Form Message Text		Claim rejected by the health plan. Review the 277 free form message text for the message provided by the plan.	The Health Plan has provided additional information within the 277 Free Form Message Text of the claim. Please review that field for additional information.
A3:104	The claim/encounter has been rejected and has not been entered into the adjudication system.	Duplicate of a previously processed claim/line.		Duplicate of a previously processed claim line.	Review claim to see if it was billed correctly as a new original or a corrected claim. Review each claim line for duplicates.
A3:107	The claim/encounter has been rejected and has not been entered into the adjudication system.	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services) Claim processed in accordance with contract provisions. (Please see Health Plan/ Healthcare Provider contract for provisional details)		Sleep study billed is not on the provider's fee schedule with CareCentrix.	Review your CareCentrix Service Registration Form (SRF) and bill according to the approved services. Ensure member does not reside in a Baycare county.
A3:109:QC	The claim/encounter has been rejected and has not been entered into the adjudication system.	Not eligible.	Patient	Patient first name, last name, DOB and/or subscriber ID are invalid or incomplete.	Verify the following patient information accurately matches the Patient's insurance card and the CareCentrix Service Registration form(if applicable): Patient first name, last name, DOB, and subscriber ID. Also, verify that the patient is eligible for the date(s) of service submitted.
A3:116	The claim/encounter has been rejected and has not been entered into the adjudication system.	Claim submitted to incorrect payer.		This Claim should not be billed to CareCentrix. The dates of service may be before or after the CareCentrix contract dates with the Health Plan, or the service being billed is not on the Health Plan fee schedule.	Verify the dates of service and the HCPCS being billed. If accurate, submit this claim directly to the Health Plan carrier. Otherwise, submit a new claim with the correct information to CareCentrix.

A3:122:85	The claim/encounter has been rejected and has not been entered into the adjudication system.	Missing/invalid data prevents payer from processing claim.	Billing Provider	Patient and provider not found in CareCentrix system.	Verify the following patient information accurately matches the Patient's insurance card and the CareCentrix Service Registration form(if applicable): Patient first name, last name, DOB, and subscriber ID. Also verify that the Provider's NPI and address both match the CareCentrix Service Registration Form. If your location shares an NPI with other locations, your claim may be rejecting because you do not have authorization on file for the service, therefore CareCentrix cannot select the appropriate rendering location.
A3:122:QC	The claim/encounter has been rejected and has not been entered into the adjudication system.	Missing/invalid data prevents payer from processing claim.	Patient	Patient first name, last name and date of birth must match data in CareCentrix intake/eligibility system.	Verify that the patient's demographic information including patient first name, last name, DOB, and subscriber ID is accurate and matches the patient's insurance card.
A3:124:DN	The claim/encounter has been rejected and has not been entered into the adjudication system.	Name, address, phone and ID number.	Referring Provider	Referring physician information is missing or invalid. Ensure provider is billing with [DN] qualifier and not [DK] qualifier for the referring physician.	Ensure you are billing the Referring Physician's name and NPI (2310A loop) and include the qualifier (DN)
A3:131:HK	The claim/encounter has been rejected and has not been entered into the adjudication system.	Medicare provider id.	Insured/Subscriber	Medicare is the primary payer, need to submit secondary claim to Health Plan.	Claim must be billed to Medicare first prior to sending claim to CCX as secondary.
A3:145:85	The claim/encounter has been rejected and has not been entered into the adjudication system.	specialty/taxonomy code.	Billing Provider	Taxonomy code missing or invalid.	Verify that a valid Billing Provider's taxonomy code is submitted on claim.
A3:153:82	The claim/encounter has been rejected and has not been entered into the adjudication system.	ID number.	Rendering Provider	Rendering provider NPI billed is not on file.	Verify that the rendering NPI submitted is on file with CareCentrix provider services. If your location shares an NPI with other locations, your claim may be rejecting because you do not have an authorization on file for that service, therefore CareCentrix cannot select the appropriate rendering location.
A3:153:85	The claim/encounter has been rejected and has not been entered into the adjudication system.	Entity's ID number.	Billing Provider	ERA Enrolled Provider -NPI Failure. ERA enrolled provider NPI mismatch.	Verify that the billing and/or rendering provider ID submitted on claim matches ERA provider ID on file.
A3:153:HK	The claim/encounter has been rejected and has not been entered into the adjudication system.	ID number.	Insured/Subscriber	Subscriber ID is invalid.	Review that subscriber ID was entered correctly in to claim and the members eligibility.
A3:157:QC	The claim/encounter has been rejected and has not been entered into the adjudication system.	Gender.	Patient	Patient gender missing.	Verify that the patient's gender is submitted on the claim.
A3:158:QC	The claim/encounter has been rejected and has not been entered into the adjudication system.	Date of birth.	Patient	Patient date of birth submitted does not match the date of birth on file at CareCentrix.	Verify that the patient's date of birth submitted on the claim is accurate.
A3:187	The claim/encounter has been rejected and has not been entered into the adjudication system.	Date(s) of service.		Claim includes future dates of service.	Verify that both the TO and FROM dates of services on the claim are prior to or equal to the date the claim is submitted to CareCentrix.
A3:21	The claim/encounter has been rejected and has not been entered into the adjudication system.	Missing or invalid information. Usage: At least one other status code is required to identify the missing or invalid information.		For details related to this rejection review the claim level free form message text on the 277.	Review the claim level free from message text and make appropriate next steps according to the information provided.
A3:228	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Type of bill for UB claim		Type of bill billed within claim is invalid.	Review Type of bill within box 4 of paper institutional claims and ensure the place of service is rendered within the patient's home.
A3:247	The claim/encounter has been rejected and has not been entered into the adjudication system.	Line information.		The procedure code is inconsistent with the modifier billed or a required modifier is missing.	Review claim line HCPCS and Modifier(s) to correct and rebill.
A3:249	The claim/encounter has been rejected and has not been entered into the adjudication system.	Place of service.		Place of service is missing or invalid	Verify that the claim billed includes the correct place of service.
A3:255	The claim/encounter has been rejected and has not been entered into the adjudication system.	Diagnosis code.		Invalid diagnosis code.	Verify that a valid diagnosis code is submitted.
A3:258	The claim/encounter has been rejected and has not been entered into the adjudication system.	Days/units for procedure/revenue code.		HCPCS units should be submitted as a whole number without decimals or fractional units.	Verify that all units are rounded to the nearest whole number.

A3:32	The claim/encounter has been rejected and has not been entered into the adjudication system.	Subscriber and policy number/contract number not found.		The Health Plan rejected the claim because the Subscriber is not active for date of service billed.	Verify with the patient that you have the correct subscriber name, date of birth and ID. Then verify with the plan that the subscriber is active for date of service billed.
A3:32:HK	The claim/encounter has been rejected and has not been entered into the adjudication system.	Subscriber and policy holder name mismatched.	Insured/Subscriber	Subscriber could be the spouse or a dependent. Claim was billed with policy holder ID rather than the patients ID.	Review the subscriber ID and eligibility of the patient.
A3:32:QC	The claim/encounter has been rejected and has not been entered into the adjudication system.	Subscriber and policyholder name mismatched.	Patient	Subscriber could be the spouse or a dependent. Claim was billed with policyholder ID rather than the patients ID or patient or dependent are no longer eligible.	Review the subscriber ID and eligibility of the patient.
A3:33	The claim/encounter has been rejected and has not been entered into the adjudication system.	Subscriber and subscriber id not found.		Subscriber ID is not found by the Health Plan.	The Subscriber may not have been found because the subscriber ID is incorrect or the patient demographic information is incorrect. Review the subscribers ID and demographic information to correct and rebill.
A3:453	The claim/encounter has been rejected and has not been entered into the adjudication system.	Procedure code modifier(s) for service(s) rendered.		HCPCS and modifier combination billed is not consistent with the HCPCS modifier combination on provider's fee schedule.	Verify that the claim was billed with the correct HCPCS/modifier combination per the CareCentrix Fee Schedule.
A3:495	The claim/encounter has been rejected and has not been entered into the adjudication system.	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit.		When a claim is split into two 835s (because the patient's plan has changed and the original claim billed contain dates of service from both coverage periods), you cannot reference the payer claim control number of the original "parent" claim.	Submit a frequency 7 void and replace claim with the changes applied to the appropriate split "child" claim and use the new payer control number returned on the split "child" claim 835.
A3:499:85	The claim/encounter has been rejected and has not been entered into the adjudication system.	No rate on file with the payer for this service	Billing Provider	HCPCS and modifier combination billed is not consistent with the HCPCS modifier combination on provider's fee schedule.	Verify that the claim was billed with the correct HCPCS/modifier combination per the CareCentrix Fee Schedule.
A3:499:MR	The claim/encounter has been rejected and has not been entered into the adjudication system.	No rate on file with the payer for this service	Payer	HCPCS and modifier combination billed is not consistent with the HCPCS modifier combination on payer's fee schedule.	Verify that the claim was billed with the correct HCPCS/modifier combination per the CareCentrix Fee Schedule.
A3:535	The claim/encounter has been rejected and has not been entered into the adjudication system.	Claim frequency code.		Rejected due to invalid claim frequency code. The corrected claim, also known as a Void and Replacement claim (Frequency 7 transaction), was rejected because the original claim is still pending adjudication.	Please wait until you receive the 835/EOP remittance advice for the original claim. Then include the CareCentrix claim number returned on the 835/EOP on your corrected claim.
A3:54	The claim/encounter has been rejected and has not been entered into the adjudication system.	Duplicate Claim		Duplicate of a previously processed claim.	Review claim to see if it was billed correctly. Do not submit duplicate claims. If a corrected claim needs to be submitted, bill with a frequency code 7 (void and replace) after receiving an 835/EOP for the original claim.
A3:570	The claim/encounter has been rejected and has not been entered into the adjudication system.	Free Form Message Text		Invalid member ID or member is not eligible.	Confirm member is eligible and the subscriber ID billed is accurate prior to billing.
A3:718	The claim/encounter has been rejected and has not been entered into the adjudication system.	Claim/service not submitted within the required timeframe (timely filing).		Claims for these members have been submitted past timely filing.	Confirm DOS submitted is within the timely filing guideline for the members plan billed. Claims submitted past 180 days from date of service per Walmart Mandate have rejected appropriately.
A3:718	The claim/encounter has been rejected and has not been entered into the adjudication system.	Claim/service not submitted within the required timeframe (timely filing).		Claim has been submitted after the timely filing timeframe.	Claims outside the timely filing deadline will not be accepted. Review the CareCentrix provider manual for timely filing guidelines.
A3:765	The claim/encounter has been rejected and has not been entered into the adjudication system.	Institutional charges are non covered.		Home infusion therapy services must be billed on a professional claim form.	Please rebill the services on a 837P or CMS 1500.
A3:765	The claim/encounter has been rejected and has not been entered into the adjudication system.	Institutional charges are non covered.		Services billed on incorrect claim form -OR - Services billed are not covered under patient's plan	Verify services are billed on the correct claim form (Institutional / Professional) and ensure member is covered by plan for services billed.

A3:787	The claim/encounter has been rejected and has not been entered into the adjudication system.	Resubmit a new claim, not a replacement claim.		CareCentrix does not accept Frequency code 7 void and replace (corrected) claims when trying to change patient information or billing provider NPI.	If you need to change the billing provider NPI or any of the following patient information on a claims that has already been submitted, you must void the claim and resubmit a new claim. - Patient Name (First Name, Last Name, and/or Middle Initial) - Patient Date of Birth - Subscriber ID (This includes changes to the prefix)
A3:789	The claim/encounter has been rejected and has not been entered into the adjudication system.	Submit these services to the patient's Medical Plan for further consideration.		Secondary claim must be billed directly to the patient's secondary Medical plan as they are out of scope of the CareCentrix contract for this payer.	Do not resubmit this claim to CareCentrix. Send directly to the patient's secondary medical plan.
A3:88:QC	The claim/encounter has been rejected and has not been entered into the adjudication system.	Not eligible for benefits for submitted dates of service.	Patient	Patient eligibility not found	Please verify that the patient is eligible with Health Plan.
A6:145:1P	The claim/encounter is missing the information specified in the Status details and has been rejected.	Specialty/taxonomy code.	Provider	Taxonomy code missing or invalid.	Verify that the Billing provider's taxonomy code is submitted on claim.
A6:153:82	The claim/encounter is missing the information specified in the Status details and has been rejected.	ID number.	Rendering Provider	NPI for rendering provider may not be on file.	Verify that the NPI for the rendering provider is correct.
A6:153:IL	The claim/encounter is missing the information specified in the Status details and has been rejected.	ID number.	Insured or Subscriber	Insured or subscriber ID not valid or incomplete.	Verify member and subscriber ID information is accurate.
A6:171	The claim/encounter is missing the information specified in the Status details and has been rejected.	Other insurance coverage information (health, liability, auto, etc.).		CareCentrix does not accept Medicare Primary claims for this Health Plan.	If the member's primary coverage is Medicare, submit the claim directly to Medicare.
A6:187	The claim/encounter is missing the information specified in the Status details and has been rejected.	Date(s) of service.		A date span should not be submitted for services billed with a unit of measure in visits or hours.	Rebill the claim with a valid date of service for services rendered.
A6:216	The claim/encounter is missing the information specified in the Status details and has been rejected.	Drug information.		National Drug Code (NDC) fields missing or format is invalid.	Review the NDC information billed and ensure its accuracy.
A6:258	The claim/encounter is missing the information specified in the Status details and has been rejected.	Days/units for procedure/revenue code.		Claim was billed with out units/days.	Verify the units/days matches codes billed.
A6:454	The claim/encounter is missing the information specified in the Status details and has been rejected.	Procedure code for services rendered.		Claim rejected due to missing HCPCS code. At least one HCPCS code required with a valid HIPPS code.	Rebill the claim with a valid HCPCS code.
A6:507	The claim/encounter is missing the information specified in the Status details and has been rejected.	HCPCS		Claim billed without at least one line with a HCPCS code - usually only a HIPPS code billed within a claim.	Verify that the claim was submitted with at least one line with a valid HCPCS code. If the claim was submitted with only a HIPPS code then resubmit as a new clean claim with the appropriate HCPCS code.
A6:513	The claim/encounter is missing the information specified in the Status details and has been rejected.	HIPPS rate code for services rendered.		Claim rejected due to missing HIPPS code. All Medicare THH claims require a valid HIPPS code.	Rebill the claim with a valid HIPPS code.
A6:658	The claim/encounter is missing the information specified in the Status details and has been rejected.	Treatment code.		Claim rejected due to missing Treatment Authorization Code (TAC). This Medicare Advantage plan requires a TAC with the HIPPS code.	Rebill the claim with a valid Treatment Authorization Code (TAC).
A6:704	The claim/encounter is missing the information specified in the Status details and has been rejected.	Claim Note Text		Missing claim level NTE Segment on a bill for denial claim.	Verify that the Bill for Denial claim contains the appropriate claim level note (NOT THE SERVICE LEVEL), which include: • DENY FOR BENEFIT MAXIMUM • DENY FOR MEDICAL NECESSITY • DENY FOR NON-COVERED BENEFIT • ADD DENY FOR NON COVERED BENEFIT • DENIED FOR NON COVERED BENEFITS • DENY FOR NON COVERED BENEFIT • DENY FOR NON COVERED BENEFITS • DENY NON COVERED BENEFIT • NON COVERED FORMULA

A6:719	The claim/encounter is missing the information specified in the Status details and has been rejected.	NUBC occurrence code(s).		This claim requires an Occurrence Code of 50 with the assessment date.	The claim should be rebilled with the Occurrence Code of 50 with the assessment date.
A6:725	The claim/encounter is missing the information specified in the Status details and has been rejected.	NUBC Value Code(s)		This claim requires a Value Code of 61 with the CBSA number for the place of residence where the home health service was delivered.	The claim should be rebilled with the Value Code of 61 with the CBSA number.
A7:116	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Claim submitted to incorrect payer.		Site of service. Verify Patient address billed, place of service and provider service location [or billing address if service location was not billed] is in scope with the specific plan billed. This claim should not be submitted to CareCentrix.	The claim should be billed to the patient's carrier. Please ensure services on behalf of Horizon members must be rendered within the state of New Jersey and BCBS claims must be rendered within the state of Florida.
A7:125:DN	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Entity's name	Referring Provider	Referring Provider is missing -OR- billed more than once on same claim	Referring Provider First Name, Last Name, and NPI must be billed. It can only billed once per claim and not repeated as a different provider type (Rendering, Ordering, etc.)
A7:145:1P	The claim/encounter has invalid information as specified in the Status details and has been rejected.	specialty/taxonomy code.	Provider	Billing provider taxonomy code missing or invalid.	Verify that a valid taxonomy code is submitted on claim.
A7:187	The claim/encounter has invalid information as specified in the Status details and has been rejected	Date(s) of service.		Claim receipt date is prior to the billed date of service within the claim.	Either correct the date of service or rebill the claim after the services have been rendered.
A7:189	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Facility admission date		Admission Date/Hour missing on claim	Admission date and Admission hour must be billed within claim and should not be left blank.
A7:218	The claim/encounter has invalid information as specified in the Status details and has been rejected.	NDC number.		NDC fields missing or format is invalid.	Review the NDC information billed and ensure its accuracy.
A7:234	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Patient Discharge Status		Interim claims must have a patient discharge status of 30 (Still a patient or expected to return for outpatient services)	Either change the discharge status to reflect that the patient is still a patient or bill a different frequency code.
A7:251	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Total anesthesia minutes.		Units/minutes billed are incorrect.	Review claim for accurate billing of units/minutes for services billed.
A7:254	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Invalid Principal Diagnosis	277 free form note-This diagnosis code may not be used as the primary diagnosis.	Claim has been submitted with an invalid principal diagnosis code that, per CMS, cannot be billed as a primary diagnosis.	Review CMS guidelines relating to billing primary diagnosis codes and bill with a valid primary diagnosis.
A7:255	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Diagnosis code.		Invalid diagnosis code. Either a diagnosis code does not exist or a primary-only diagnosis code has been used in an additional diagnosis field.	Verify that the diagnosis codes submitted are all valid. If the free form text is populated, then verify that all additional diagnosis codes are not primary-only codes.
A7:258	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Days/units for procedure/revenue code.		HIPPS code must be billed with a unit value of 1. Claim rejected due to the number of units billed NOT equal to 1.	Verify that HIPPS codes submitted on the claim have a unit value of 1 and billed charges of zero.
A7:26:82	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Entity not found.	Rendering Provider	Rendering provider not on file.	Verify that the rendering provider NPI submitted on the claim is correct for the rendering provider location, and that it matches the CareCentrix Service Registration Form. If you feel the correct NPI has been billed, please contact your designated Carecentrix Contract Manager to have your rendering provider NPI reviewed and possibly added or updated in our system. You may locate your designated Contract Manager by clicking on the link : http://help.carecentrix.com/ProviderResources/Network_Management_Contact_List.pdf Otherwise, rebill with corrected information.

A7:26:85	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Entity not found.	Billing Provider	Billing provider not on file.	Verify that the billing provider NPI submitted on the claim is the correct NPI for the billing provider location. If you feel the correct NPI has been billed, please contact your designated Carecentrix Contract Manager to have the billing provider NPI reviewed and possibly added or updated in our system. You may locate your designated Contract Manager by clicking on the link : http://help.carecentrix.com/ProviderResources/Network_Management_Contact_List.pdf Otherwise, rebill with corrected information.
A7:26:QC	The claim/encounter has invalid information as specified in the Status details and has been rejected	Entity not found.	Patient	Patient registration was not found. Either the Provider has not registered the patient with CareCentrix or the patient's first name, last name, DOB and/or subscriber ID are incorrect , and do not match CareCentrix records.	Verify that the patient's demographic information (patient first name, last name, DOB, and subscriber ID) matches the Service Registration Form (SRF) and the patient's insurance card. In addition, verify the patient is eligible for the date of service billed as well as ensuring the information on the SRF is accurate. Please contact CareCentrix to have the SRF updated if changes are needed.
A7:33	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Subscriber and subscriber ID not found.		Invalid subscriber ID.	Verify the patient information accurately matches the subscriber ID on the patient's insurance card.
A7:33	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Subscriber and subscriber id not found.		Subscriber or Subscriber ID is not found by the Health Plan.	The Subscriber may not have been found because the subscriber ID is incorrect or the patient demographic information is incorrect. Review the subscribers ID and demographic information to correct and rebill.
A7:455	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Revenue code for services rendered.		Revenue code billed is invalid.	Please review the revenue code and make the appropriate corrections. The revenue code will not be found within your service registration form[SRF] from CareCentrix. See National Uniform Billing Committee (NUBC) Codes for all revenue codes.
A7:476	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Missing or invalid units of service.		Units billed do not match the date span billed.	Verify that the date span submitted on the claim is valid, and that the units are appropriate.
A7:481	The claim/encounter has invalid information as specified in the Status details and has been rejected	Claim/submission format is invalid.		Claim was submitted on incorrect claim form	Ensure that any Traditional Home Health (THH) services for this patient are billed on an institutional form/transaction [837I/UBO4] and Durable Medical Equipment and/ or Orthotic and Prosthetics are billed within a professional claim form/transaction [837P/1500].
A7:500:77	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Zip Code	Service Location	Service location zip code billed is either invalid or not on file with CareCentrix	Verify service location zip code is valid. If it is valid, please contact CareCentrix to ensure the correct loaction information is on file and registered with CareCentrix.
A7:500:82	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Zip Code	Rendering Provider	Provider NPI# is not active or not on file with CareCentrix - OR - Service NPI# is a duplicate - OR - Service Facility Zip Code (first 5 digits) does not match service facility address on file for provider.	Verify that the claim was billed with the correct NPI. If not, rebill the claim with the correct rendering NPI. If your location shares an NPI with other locations, you must bill with the service facility address that is on file with CareCentrix for the rendering provider location. If the NPI on the claim was correct, contact CareCentrix to ensure this location information is on file with CareCentrix for the date of service billed.
A7:500:82	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Zip Code	Billing Provider	Billing Provider location zip code billed is either invalid or not on file with CareCentrix	Verify billing location zip code is valid. If it is valid, please contact CareCentrix to ensure the correct loaction information is on file and registered with CareCentrix.

A7:500:IL	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Zip Code	Insured or Subscriber	Patient or Subscriber zip code is invalid for the address provided.	Verify the zip code billed is valid for the patient or subscriber's address.
A7:507	The claim/encounter has invalid information as specified in the Status details and has been rejected.	HCPCS		The provider has billed an expired or invalid HIPPS code.	Rebill the claim with proper HIPPS code.
A7:507:1P	The claim/encounter has invalid information as specified in the Status details and has been rejected.	HCPCS	Provider	The provider has billed an expired or invalid HIPPS code.	Rebill the claim with proper HIPPS code.
A7:510	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Future date.		Future date billed	Either correct the date of service or rebill the claim after the services have been rendered.
A7:513	The claim/encounter has invalid information as specified in the Status details and has been rejected.	HIPPS-rate code for services rendered is not valid.		HIPPS line was submitted with an invalid HIPPS code.	Verify that any institutional claim line with a revenue code of '0022', '0023' or '0024' contains a valid HIPPS code.
A7:562: 85	The claim/encounter has invalid information as specified in the Status details and has been rejected.	National Provider Identifier (NPI).	Billing Provider	Billing provider NPI is incorrect, invalid, or not on file.	Please verify that the billing provider NPI submitted on the claim is the correct NPI for the billing provider location. If you feel the correct NPI has been billed, please contact your designated Contract Manager within CareCentrix to have your billing provider NPI reviewed and possibly added or updated in our system. You may locate your designated Contract Manager by clicking on the link : http://help.carecentrix.com/ProviderResources/Network_Management_Contact_List.pdf Otherwise, rebill with corrected information.
A7:562:1P	The claim/encounter has invalid information as specified in the Status details and has been rejected.	National Provider Identifier (NPI).	Provider	Referring provider's first name, last name and NPI are missing or invalid. -OR- The rendering provider's NPI is not on file.	Please verify that the referring provider information is submitted on the claim with a DN qualifier within loop 2310A. If you feel the correct referring provider information has been billed, please contact your designated Contract Manager to have your Rendering Provider NPI# reviewed and possibly added or updated in our system. Otherwise, rebill with corrected information.
A7:562:82	The claim/encounter has invalid information as specified in the Status details and has been rejected.	National Provider Identifier (NPI).	Rendering Provider	Rendering provider NPI is missing or invalid, or not on file.	Verify Rendering Provider is on file with CareCentrix and credentialled for plan billed. If you feel the correct Rendering Provider information has been billed, please contact your designated Carecentrix Contract Manager to have your Rendering Provider NPI# reviewed and possibly added or updated in our system. You may locate your designated Contract Manager by clicking on the link : http://help.carecentrix.com/ProviderResources/Network_Management_Contact_List.pdf Otherwise, rebill with corrected information.
A7:565:QC	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Estimated Claim Due Amount	Patient	Patient Estimated Amount Due is either missing or should not be greater than the total charge amount.	Patient Responsibility is billed without a dollar amount or is billed with an amount greater than the total billed amount.
A7:583	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Line item charge amount.		HIPPS line contains billed charges in greater than $0.00.	Verify that any institutional claim HIPPS line (with a revenue code of '0022', '0023' or '0024') contains billed charges of zero.
A7:720	The claim/encounter has invalid information as specified in the Status details and has been rejected.	NUBC occurrence code date(s).		An occurrence code is present on the claim that requires a corresponding date.	Verify that the occurrence code billed has a valid corresponding date submitted in the MMDDYY format.
A7:743:1P	The claim/encounter has invalid information as specified in the Status details and has been rejected.	Credential/enrollment information.	Provider	Provider credentialing is not on file/loaded for plan billed.	Contact your designated Contract Manager within CareCentrix to verify that the NPI is on file for the health plan billed.

A8:125	**Rejected for relational field in error.**	**Entity's name**		**Provider information is duplicated within the claim under different provider types (Attending, Rendering, Referring, Ordering, etc.)**	**Provider First Name, Last Name, and NPI can only be billed once per claim for a single provider type (Attending, Rendering, Referring, Ordering, etc.)**
A8:189	**Rejected for relational field in error.**	**Facility admission date**		**Admission Date/Hour missing or invalid on claim**	**When billing a claim associated with an accident or workers comp situation, verify that the correct incident date has been billed within claim**
A8:727	**Rejected for relational field in error.**	**Accident date**		**Either the claim was billed indicating that the services were performed due to an accident but no accident date was provided, or, the claim did not indicate that an accident had occurred but an accident date was provided.**	**Verify if services were performed due to an accident. If not, ensure all accident fields of claim are left blank. If yes, ensure to fill out all required information relating to accident.**
This column contains the claim rejection codes returned on a 277CA EDI transaction. Each code actually consists of 3 separate codes that are concatenated and delineated by a colon: CATEGORY:STATUS:ENTITY	This column contains the industry standard description for the **first** of the 3 codes that make up a rejection code known as the **CATEGORY.** This code conveys the broad claim status category, i.e. If the claim was accepted, rejected, rejected due to missing information, or rejected due to invalid information.	This column contains the industry standard description for the second of the 3 codes that make up a rejection code known as the **STATUS.** This code gives you more details on the reason the claim was rejected. If the first code, CATEGORY, indicated that data was missing or invalid, this code will tell you which specific field is in error.	This column contains the industry standard description for the third of the 3 codes that make up a rejection code know as the ENTITY. It is WHO the STATUS is referring to. NOTE: This code is situational and not always provided.	This column contains CareCentrix's explanation for the rejection.	This column contains any steps that the provider can take prior to submitting a new claim for acceptance.