

United Platform Proprietary Code	United Platform Proprietary Description	ANSI Claim Adjustment Group Code	ANSI Claim Adjustment Reason Code
AA		PR	96
AB	THESE CHARGES WERE INCORRECTLY PAID BY MEDICARE AS PRIME CARRIER. WE HAVE REDUCED THIS PAYMENT BY THE AMOUNT PREVIOUSLY PAID BY MEDICARE AND ISSUED REPAYMENT DIRECTLY TO MEDICARE TO THE EXTENT OF THE PLAN'S LIABILITY. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE TOTAL ALLOWABLE AMOUNTS ON THIS STATEMENT AND THE AMOUNTS PAID BY THE PLAN AND MEDICARE AS INDICATED ON THEIR STATEMENT. MEDICARE COULD BE E-BILLED FOR ANY BALANCE ONCE THEY HAVE ADJUSTED THEIR RECORDS TO INDICATE THEY ARE THE SECONDARY PAYER.		
AC	SERVICE BILLED IS PART OF THE GLOBAL CHARGE WHICH HAS BEEN PREVIOUSLY SUBMITTED FOR REIMBURSEMENT BY ANOTHER HEALTH CARE PROVIDER.	CO	96
AD	CHARGES ARE NOT ELIGIBLE BECAUSE THEY FALL WITHIN THE GLOBAL DAYS TIME FRAME.	CO	96
AE	CHARGES CANNOT BE CONSIDERED BECAUSE WE ARE UNABLE TO VERIFY AN ACTIVE LICENSE FOR THIS PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.	CO	96
AF	REIMBURSEMENT HAS BEEN PREVIOUSLY ISSUED FOR THESE DATES OF SERVICE.	CO	18
AG	THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL BILLING FOR THIS SERVICE IS NOT ELIGIBLE FOR REIMBURSEMENT.	CO	170
AH	HOSPITAL NURSING SERVICES ARE USUALLY INCLUDED IN THE HOSPITAL ROOM AND BOARD CHARGES. NO BENEFITS ARE PAYABLE FOR SEPARATE NURSING CHARGES.	OA	B15
AI	YOU MUST CONTACT MBC AT THE TELEPHONE NUMBER LISTED ON YOUR ID CARD FOR ALL MENTAL HEALTH AND SUBSTANCE ABUSE (MH/SA) CARE IN ORDER TO RECEIVE MAXIMUM BENEFITS.	CO	62
AJ	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REDUCED IN PART OR IN WHOLE BASED ON A REVIEW BY ADVANA. WORKERS' COMPENSATION CLAIMS ARE NOT A COVERED BENEFIT UNDER YOUR MEDICAL PLAN. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ADVANA AT 1-866-802-8560.	PR	22
AK	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REDUCED IN PART OR IN WHOLE BASED ON A REVIEW BY ADVANA INDICATING ANOTHER PARTY HAS PAID THESE CHARGES. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ADVANA AT 1-866-802-8560.	PR	22
AL	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REDUCED IN PART OR IN WHOLE BASED ON A REVIEW BY ADVANA INDICATING THE REDUCTION WAS AT THE EMPLOYEE'S REQUEST. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ADVANA AT 1-866-802-8560.	PR	22
AM	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REDUCED IN PART OR IN WHOLE BASED ON A REVIEW BY ADVANA INDICATING MEDICAL PAYMENT/PERSONAL INJURY PROTECTION COVERAGE IS PRIMARY TO YOUR MEDICAL BENEFITS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ADVANA AT 1-866-802-8560.	PR	22
AN	THIS PHYSICIAN OR PROVIDER PARTICIPATES IN THE NORTH TEXAS HEALTH NETWORK PLAN. ALL CLAIMS MUST BE SENT TO NORTH TEXAS HEALTH NETWORK, P.O. BOX 167768, IRVING, TX 75016-7768.	CO	109
AO	YOUR ANNUAL WELL WOMEN EXAM BENEFIT IS ONLY PAYABLE WHEN A PAP SMEAR IS PERFORMED. TO DATE, WE HAVE NOT RECEIVED A PAP SMEAR BILL. IF A PAP SMEAR WAS PERFORMED, PLEASE CONTACT YOUR PHYSICIAN AND REQUEST THAT HE OR SHE SUBMIT VERIFICATION THAT THIS SERVICE WAS PERFORMED.	PR	96
AP	THIS PROVIDER AGREED TO ACCEPT THE DISCOUNTED AMOUNT AS PAYMENT IN FULL. YOU ARE NOT RESPONSIBLE FOR THIS DISCOUNTED AMOUNT.	CO	A2
AQ	WE HAVE LIMITED YOUR OUT-OF-POCKET EXPENSES BASED ON YOUR PRIOR PLAN'S BENEFIT PROVISION.	CO	2
AR	CPT CODE AND/OR MODIFIER BILLED IS INCORRECT.	CO	4
AS	REVENUE CODE IS INCORRECT. PLEASE SUBMIT AN ITEMIZED BILL FOR CONSIDERATION.	CO	17
AT	YOUR MEDICAL EXPENSE PLAN REQUIRES YOU TO NOTIFY US FOR THIS SERVICE. BECAUSE OUR RECORDS INDICATE YOU DID NOT NOTIFY US, YOUR BENEFITS HAVE BEEN REDUCED. PLEASE CALL THE NUMBER ON THE BACK OF YOUR ID CARD IF YOU HAVE ANY QUESTIONS ABOUT SERVICES THAT REQUIRE PRIOR NOTIFICATION.	PR	62
AU	CHARGES CANNOT BE CONSIDERED BECAUSE THE CPT CODE BILLED IS DELETED/ EXPIRED.	CO	17

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AV	INCORRECT RECORDS WERE SUBMITTED FOR THE SERVICE UNDER REVIEW.	CO	17
AW	CHARGES CANNOT BE CONSIDERED BECAUSE CORPORATE STATUS IS SUSPENDED/ INACTIVE OR UNABLE TO BE VERIFIED.	CO	96
AX	CHARGES CANNOT BE CONSIDERED BECAUSE NO UNITS WERE BILLED, UNITS EXCEED MAXIMUM AND/OR ARE UNSUPPORTED BY THE SUBMITTED DOCUMENTATION.	CO	42
AY	THE PROCEDURE CODE SUBMITTED IS NOT ELIGIBLE FOR PAYMENT. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	96
AZ	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR THE SURGICAL TREATMENT AND NON-SURGICAL, MEDICAL TREATMENT OF OBESITY (INCLUDING MORBID OBESITY).	PR	96
A0		CO	42
A1			
A2			
A3		CO	B20
A4			
A5			
A6	THIS CLAIM WAS SUBMITTED BY UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP) AND IS FOR CHARGES THAT WERE PREVIOUSLY PAID UNDER THE USFHP PROGRAM.	OA	23
A7			
A9	IN ORDER TO BE REIMBURSED FOR YOUR DRUG CLAIMS, PLEASE HAVE YOUR PHARMACIST COMPLETE A DIRECT MEMBER REIMBURSEMENT CLAIM FORM AND PROVIDE YOU WITH NEW PRESCRIPTION RECEIPTS. THEN SUBMIT THE FORM AND RECEIPTS TO THE ADDRESS INDICATED ON THE FORM. IF YOU NEED TO OBTAIN A DIRECT MEMBER REIMBURSEMENT CLAIM FORM, CALL THE CUSTOMER CARE NUMBER ON YOUR IDENTIFICATION CARD.	OA	16
BA	THIS SERVICE LINE CONTAINS AN ADD ON CODE THAT HAS A MAXIMUM ALLOWABLE OF 60 MINUTES. ADDITIONAL MINUTES THAT EXCEED 60 HAVE BEEN ADDED TO THE PRIMARY PROCEDURE.	CO	42
BB	THIS SERVICE LINE HAS BEEN MODIFIED TO INCLUDE THE REMAINING MINUTES GREATER THAN 60 FROM THE ADD ON CODE.	CO	42
BC	THIS SERVICE LINE HAS BEEN REPORTED UNDER ANOTHER PROCEDURE CODE AND IS NOT COVERED SEPARATELY.	CO	B15
BD	RESPONSE FOR REQUESTED INFORMATION WAS NOT RECEIVED WITHIN STATE MANDATED TIMEFRAME.	PR	138
BE	THIS SERVICE LINE HAS BEEN RECODED TO ADJUST THE MINUTES.	CO	B15
BI	THIS SERVICE REPRESENTS AN ADD ON CODE AND MUST BE REPORTED WITH A PRIMARY PROCEDURE.	CO	B15
BF	YOUR PLAN HAS A LIMITED SCHEDULED BENEFIT. IT IS NOT SUBJECT TO REASONABLE AND CUSTOMARY OR A PROVIDER DISCOUNT. PLEASE REFER TO YOUR PLAN CERTIFICATE OR CALL OUR CUSTOMER CARE LINE AT 1-800-641-4146	PR	35
BG	UNDER YOUR MAJOR MEDICAL BENEFIT, IN HOSPITAL ROOM AND BOARD CHARGES AND PHYSICIAN FEES HAVE A MAXIMUM ALLOWABLE AMOUNT. WE HAVE PAID THE MAXIMUM ALLOWABLE AMOUNT. YOU ARE RESPONSIBLE FOR THE NOT COVERED AMOUNTS.	PR	35
BJ	RESPONSE FOR REQUESTED INFORMATION WAS NOT RECEIVED WITHIN STATE MANDATED TIMEFRAME.	CO	138
BK	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE THIS CLAIM HAS BEEN REDUCED IN PART OR IN WHOLE DUE TO THE EMPLOYEE NOT RESPONDING TO A REQUEST FOR NEEDED INFORMATION FROM ADVANA. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ADVANA AT 1-866-802-8560.	PR	22
BL	YOUR PLAN ONLY COVERS INPATIENT HOSPITAL EXPENSES. PLEASE SUBMIT THIS EXPENSE TO THE APPROPRIATE CARRIER.	PR	109
BN	YOUR PLAN ONLY COVERS PRESCRIPTION DRUG EXPENSES. PLEASE SUBMIT THIS EXPENSE TO THE APPROPRIATE CARRIER.	PR	109
BO	YOUR PLAN ONLY COVERS MENTAL HEALTH EXPENSES. PLEASE SUBMIT THIS EXPENSE TO THE APPROPRIATE CARRIER.	PR	109
BP	YOUR BENEFIT PLAN REQUIRES YOU TO CONTACT VALUEOPTIONS BEFORE RECEIVING TREATMENT FOR THIS CONDITION. BECAUSE YOU DID NOT CONTACT VALUEOPTIONS, THESE CHARGES ARE BEING PAID AT THE LOWER LEVEL OF BENEFITS.	CO	95
BQ	YOUR PLAN ONLY COVERS EMPLOYEE ASSISTANCE PROGRAM (EAP) EXPENSES. PLEASE SUBMIT THIS EXPENSE TO THE APPROPRIATE CARRIER.	PR	109
BS	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. ALTHOUGH THIS CLAIM HAS BEEN PROCESSED FOR PAYMENT, ADDITIONAL	PR	22

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	INFORMATION IS NEEDED. PLEASE CONTACT ADVANA AT 1-866-802-8560 TO PROVIDE THIS INFORMATION.		
BR	YOUR PLAN ONLY COVERS WORKER'S COMPENSATION EXPENSES. PLEASE SUBMIT THIS EXPENSE TO THE APPROPRIATE CARRIER.	PR	109
BU	THE EXTRA CHARGE FOR CARE BEFORE OR AFTER YOUR SURGERY IS NOT COVERED. THE SURGICAL FEE THAT IS COVERED INCLUDES AN ALLOWANCE FOR CARE BEFORE AND AFTER THE SURGERY. THIS IS TRUE WHETHER THE EXTRA CHARGE IS COMBINED WITH THE SURGICAL FEE OR LISTED BY ITSELF.	CO	59
BV	THIS PROCEDURE CODE IS NOT ELIGIBLE FOR AN ASSISTANT SURGEON OR CO-SURGEON SERVICES. THEREFORE BENEFITS ARE NOT PAYABLE.	OA	54
BW	BASED ON THE INFORMATION PROVIDED, THIS SERVICE IS COSMETIC AND IS NOT COVERED. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT MEDICAL RECORDS THAT DEMONSTRATE A PHYSIOLOGICAL FUNCTIONAL IMPAIRMENT, ALONG WITH AN EXPLANATION SHOWING HOW THIS SERVICE IMPROVES OR RESOLVES SUCH FUNCTIONAL IMPAIRMENT AND MEETS THE REQUIREMENTS INDICATED IN YOUR BENEFIT PLAN LANGUAGE.	PR	50
BX	IF APPLICABLE TO YOUR CONTRACT, THIS STATE MANDATED SURCHARGE WILL BE PAID DIRECTLY TO THE LOUISIANA HEALTH INSURANCE ASSOCIATION.	OA	45
BY	YOUR PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	OA	131
BZ	YOUR HEALTH CARE PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. HOWEVER, YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	OA	131
B0	SERVICES REPORTED WITH MODIFIER AD ARE REIMBURSED AT A BASE UNIT VALUE OF 3. NO ADDITIONAL REIMBURSEMENT IS PROVIDED FOR REPORTED ANESTHESIA TIME.	CO	B15
B1	YOUR BENEFITS ARE LOWER BECAUSE YOU DID NOT NOTIFY CARE COORDINATION.	CO	62
B2	YOUR BENEFITS ARE LOWER BECAUSE YOU DID NOT NOTIFY CARE COORDINATION AND YOU USED A NON-NETWORK FACILITY.	CO	62
B3	YOUR BENEFITS ARE LOWER BECAUSE YOU DID NOT GET A SECOND SURGICAL OPINION AND YOU DID NOT NOTIFY CARE COORDINATION.	CO	61
B4	YOUR PLAN DOES NOT COVER SERVICES THAT DO NOT MEET COVERAGE REQUIREMENTS. THE CARE COORDINATOR HAS DETERMINED THAT THIS SERVICE DOES NOT MEET COVERAGE REQUIREMENTS, THEREFORE BENEFITS ARE NOT AVAILABLE.	PR	50
B7	AFTER REVIEWING YOUR REQUEST FOR ADDITIONAL REIMBURSEMENT, WE HAVE DETERMINED THAT BENEFITS HAVE BEEN PAID ACCORDING TO THE PLAN, AND NO ADDITIONAL PAYMENT IS DUE.	PR	96
B8	ACCORDING TO YOUR PLAN, YOUR BENEFITS ARE LOWER BECAUSE YOUR CARE WAS COORDINATED BY A NON-NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.	PR	38
B9		PR	3
CA	CORRECTED BILLING OR ADDITIONAL LATE CHARGES HAVE BEEN CONSIDERED. THE CONTRACTED AMOUNT FOR THIS CLAIM WAS PREVIOUSLY ALLOWED AND HAS BEEN ISSUED. NO FURTHER PAYMENT IS DUE. THE PATIENT IS NOT RESPONSIBLE FOR THE CHARGES.	CO	42
CB	PLEASE SEND CLAIM DIRECTLY TO UNITED BEHAVIORAL HEALTH FOR PROCESSING. UNITED BEHAVIORAL HEALTH, P.O. BOX 30755, SALT LAKE CITY, UT 84130-0755.	PR	109
CC	THIS CLAIM HAS BEEN FORWARDED TO UNITED BEHAVIORAL HEALTH FOR YOU. PLEASE SUBMIT FUTURE CLAIMS FOR MENTAL HEALTH, ALCOHOLISM AND SUBSTANCE ABUSE TO UNITED BEHAVIORAL HEALTH FOR PROCESSING. UNITED BEHAVIORAL HEALTH, P.O. BOX 30755, SALT LAKE CITY, UT 84130-0755.	PR	109
CD	THE AMOUNT BILLED IS MORE THAN THE AMOUNT ALLOWED UNDER YOUR EMPLOYER'S PLAN.	PR	45
CE	WE HAVE RECEIVED MORE INFORMATION REGARDING YOUR CLAIM AND HAVE PROCESSED IT ACCORDING TO THE BENEFITS AVAILABLE UNDER YOUR PLAN.		
CF	WE HAVE RECEIVED MORE INFORMATION REGARDING YOUR CLAIM AND HAVE PROCESSED IT ACCORDING TO THE BENEFITS AVAILABLE UNDER YOUR PLAN.		
CG	THIS PERSON IS NOT COVERED FOR THIS CONDITION UNDER THIS PLAN.	PR	167
CH	CHARGES SUBMITTED SHOW A DELETED, UNLISTED, OR INAPPROPRIATE CPT-4/ HCPCS CODE. TO CONSIDER THIS CLAIM, PLEASE SEND A NEW BILL WITH AN ACTIVE CODE. IF THE CODE IS UNLISTED, PLEASE SEND A DESCRIPTION. IF THE	CO	17

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CM	IS FOR ANESTHESIA, WE WILL NEED THE APPROPRIATE ASA/CPT-4 CODE CROSSWALK, THE TIME IN MINUTES, AND ANY MODIFIERS. YOUR GROUP HEALTH PLAN CONTAINS A PRE-EXISTING CONDITION LIMITATION. SINCE THESE EXPENSES RELATE TO A CONDITION WHICH WE HAVE DETERMINED FALL UNDER THE PRE-EXISTING LIMITATION, NO COMPREHENSIVE OR MAJOR MEDICAL BENEFITS ARE AVAILABLE AT THIS TIME.	CO	51
CP	YOUR PLAN ONLY COVERS THIS SERVICE WHEN PROVIDED BY A PHYSICIAN.	CO	12
CQ	YOU DO NOT HAVE ANY BENEFITS AVAILABLE FOR THIS SERVICE. YOU USED THEM BETWEEN THE TIME WE WERE INITIALLY NOTIFIED OF THE SERVICES AND THE TIME WE RECEIVED THIS CLAIM FOR PAYMENT.	PR	35
CR	YOU DID NOT SUBMIT YOUR OVER-THE-COUNTER DRUGS BILL WITH A PRESCRIPTION RECEIPT SHOWING THE DATE AND PRESCRIPTION NUMBER SO NO PAYMENT WILL BE MADE.	PR	B17
CS	THIS ITEMIZED SERVICE AND CHARGE HAVE BEEN ADJUSTED TO REFLECT MORE ACCURATELY THE SERVICE(S) PROVIDED.	CO	B15
CT	THIS EXPENSE IS NOT COVERED BY YOUR PLAN.	PR	96
CV	WE RECEIVED YOUR CLAIM AND ARE UNABLE TO MAKE A COMPLETE BENEFIT DETERMINATION WITHIN THE 45-DAY PROMPT PAYMENT TIME FRAME WITHOUT ADDITIONAL INFORMATION. PLEASE REFER TO OUR CORRESPONDENCE INDICATING THE ADDITIONAL INFORMATION NECESSARY TO COMPLETE THE BENEFIT DETERMINATION OF YOUR CLAIM.	CO	17
CW	THIS SERVICE IS NOT FOR THE DIRECT CARE OR TREATMENT OF THE PATIENT. BENEFITS ARE NOT PAYABLE FOR THIS EXPENSE.	PR	96
CX	THE PHYSICIAN'S CHARGE USUALLY INCLUDES THE USE OF THE HOSPITAL OR CLINIC. BENEFITS FOR THE USE OF A HOSPITAL OR CLINIC BY THE PHYSICIAN ARE NOT PAID SEPARATELY. YOU ARE ONLY RESPONSIBLE FOR THE "PATIENT PAYS" AMOUNT ON YOUR STATEMENT.	OA	B15
CY	THIS CHARGE HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE USUAL, REASONABLE AND CUSTOMARY CHARGE FOR YOUR AREA. THIS AMOUNT IS DETERMINED BY THE OUTPATIENT FACILITIES INDEX.	PR	45
CZ	IF YOU ARE BILLED FOR THE NOT COVERED AMOUNT, PLEASE CALL CONCENTRA PREFERRED SYSTEMS DIRECTLY AT 1-800-598-6888. WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE HAVE RECEIVED.		
C0	THE CPT BILLED INDICATES MANIPULATION OF MORE REGIONS THAN DELINEATED ON THE NOTIFICATION RESPONSE SENT TO THE HEALTH CARE PROVIDER BY ACN GROUP. PAYMENT WAS MADE AT THE INDICATED LEVEL.	CO	62
C2	THIS SERVICE WILL BE COVERED UNDER YOUR MEDICAL PLAN FOR ONE VISIT TO A MEDICAL DOCTOR (M.D.). FOR PLAN COVERAGE BEYOND THE INITIAL VISIT, YOU MUST CONTACT MAGELLAN AT 1-800-872-4711 FOR THEIR REVIEW.	CO	35
C3	THE DATE OF SERVICE FOR THIS CLAIM IS PRIOR TO THE EFFECTIVE DATE OF COVERAGE UNDER THIS PLAN. PLEASE RESUBMIT THIS CLAIM TO YOUR PRIOR CARRIER.	PR	26
C4	THE PROCEDURE CODE SUBMITTED IS NOT APPROPRIATE BASED ON THE AGE OF THE PATIENT. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS SERVICE.	CO	6
C5	YOUR PLAN COVERS REASONABLE CHARGES FOR THERAPEUTIC TREATMENT OF SICKNESS OR INJURY. THE REASONABLE CHARGE IS BASED ON AMOUNTS CHARGED BY OTHER PROVIDERS FOR SIMILAR SERVICES OR SUPPLIES.	OA	45
C6	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR ORGAN OR TISSUE TRANSPLANTS.	PR	96
C7	THE PROCEDURE CODE SUBMITTED IS NOT APPROPRIATE BASED ON THE GENDER OF THE PATIENT. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS SERVICE.	PR	7
C9	EMERGENCY ROOM TREATMENT FOR THIS CONDITION HAS RESULTED IN A DEDUCTIBLE.	PR	1
DA	WE USED A NETWORK FEE BECAUSE YOU USED A NETWORK FACILITY. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	OA	A2
DB	CARE COORDINATION WAS NOT NOTIFIED AS REQUIRED AND SERVICES WERE RENDERED BY A NON-PREFERRED PROVIDER. TO CONTROL YOUR HEALTH EXPENSE BENEFITS, YOU ARE ENCOURAGED TO NOTIFY US WHEN USING NON-PREFERRED PROVIDERS OR USE PREFERRED PROVIDERS.	PR	62
DC	THE EXCLUDED AMOUNT REPRESENTS THE PENALTY FOR NOT NOTIFYING THE CARE COORDINATION UNIT.	PR	62
DD	YOUR PLAN MAY PROVIDE YOU WITH NETWORK PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS. VISITS TO NETWORK PHYSICIANS OR HEALTH CARE	CO	38

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	PROFESSIONALS GENERALLY COST LESS THAN VISITS TO THOSE PHYSICIANS NOT IN THE NETWORK.		
DE	THESE SERVICES ARE NOT COVERED UNDER YOUR MEDICAL PLAN, BUT ARE COVERED UNDER YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA). YOUR CLAIM HAS BEEN FORWARDED TO THE APPROPRIATE UNIT FOR PROCESSING.	PR	96
DF	THESE CHARGES HAVE BEEN PAID UNDER YOUR PRESCRIPTION DRUG PLAN. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	96
DG	THIS REPRESENTS THE HOSPITAL PER-CONFINEMENT DEDUCTIBLE/COPAY APPLIED EACH TIME THERE IS A HOSPITAL ADMISSION. IT DOES NOT APPLY TO YOUR CALENDAR YEAR DEDUCTIBLE.	PR	1
DH	THESE SERVICES ARE FOR SELF ADMINISTERED DRUGS RECEIVED IN A HOSPITAL SETTING. WHEN RECEIVED IN A HOSPITAL SETTING, THESE SERVICES ARE NOT COVERED BY YOUR PLAN.	OA	96
DI	WE HAVE APPLIED AN OUT-OF-NETWORK DEDUCTIBLE BECAUSE YOU DID NOT USE A NETWORK PROVIDER.	PR	1
DJ	YOUR EXPENSES HAVE BEEN APPLIED TO AN OUT-OF-NETWORK OUT-OF-POCKET BECAUSE YOU DID NOT USE A NETWORK PROVIDER.	PR	38
DK	THANK YOU FOR THE NOTIFICATION. WE HAVE USED THE HIGHER BENEFIT LEVEL.	OA	2
DL	ACCORDING TO YOUR PLAN, EXAMINATIONS, CONSULTATIONS, AND NON-SURGICAL TREATMENTS PERFORMED IN THE PATIENT'S HOME ARE NOT COVERED.	PR	58
DM	THIS TREATMENT WAS CONSIDERED AT THE 50% LEVEL SINCE THE SERVICES ARE BEYOND THE GUIDELINES APPROVED BY EAP MANAGED HEALTH CARE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT EAP AT 1-800-628-8392.	OA	62
DN	CHARGES SUBMITTED SHOW AN INCORRECT DATE OF SERVICE AND/OR PATIENT NAME.	CO	17
DO	YOUR PLAN DOES NOT COVER THE SERVICES YOU RECEIVED FROM THIS PHYSICIAN OR HEALTH CARE PROVIDER.	PR	170
DQ	COMPREHENSIVE HEALTH GROUP IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
DS	THIS CLAIM HAS BEEN PAID IN ACCORDANCE WITH THE CONTRACT AGREEMENT. DO NOT BILL THE PATIENT.	CO	A2
DT	WE HAVE RECEIVED ADDITIONAL INFORMATION REGARDING APPLICATION OF A DISCOUNT AND REPROCESSED YOUR CLAIM.		
DU	ACCORDING TO YOUR PLAN, YOU ARE REQUIRED TO USE A NETWORK PHYSICIAN. OUR RECORDS SHOW THAT YOU DID NOT USE YOUR PRIMARY PHYSICIAN OR A NETWORK HEALTH CARE PROVIDER. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	38
DV	ACCORDING TO YOUR BENEFIT PLAN, THESE CHARGES WOULD BE COVERED UNDER YOUR PRIOR PLAN'S EXTENDED BENEFITS PROVISION. THEREFORE, NO BENEFITS ARE PAYABLE UNDER THIS PLAN. PLEASE RESUBMIT THIS CLAIM AND ALL CLAIMS RELATED TO THIS EXPENSE TO YOUR PRIOR MEDICAL BENEFITS CARRIER.	PR	96
DW	YOUR PLAN DOES NOT COVER THIS PRESCRIPTION DRUG.	PR	96
DX	THIS CLAIM WAS PAID BASED ON STATE MANDATED BENEFIT PROVISIONS.	CO	45
DY	YOUR PLAN DOES NOT COVER SERVICES AND SUPPLIES FOR SMOKING CESSATION PROGRAMS OR THE TREATMENT OF NICOTINE ADDICTION.	PR	96
DZ	YOUR PRESCRIPTION DRUGS ARE COVERED BY THE CAREMARK PRESCRIPTION DRUG PROGRAM EFFECTIVE APRIL 1, 1992. IF YOU HAVE ANY QUESTIONS, PLEASE CALL 1-800-237-2767.	OA	109
D0	YOUR PRESCRIPTION DRUG CLAIM WAS MISDIRECTED TO OUR OFFICE. PLEASE SEND THIS AND ALL FUTURE CLAIMS FOR PRESCRIPTION DRUGS TO YOUR EMPLOYER'S DRUG PLAN ADMINISTRATOR FOR CONSIDERATION.	OA	109
D1	THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE AMOUNTS AND AMOUNTS OVER THE ANNUAL BENEFIT LIMITS FOR THIS SERVICE, UP TO THE ELIGIBLE EXPENSE.	CO	A2
D2	THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE AMOUNTS AND AMOUNTS OVER THE ANNUAL BENEFIT LIMITS FOR THIS SERVICE, UP TO THE ELIGIBLE EXPENSE.	CO	A2
D3	YOUR BENEFITS ARE LOWER BECAUSE, ACCORDING TO OUR RECORDS, WE DID	PR	62

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D5	NOT RECEIVE NOTIFICATION AND YOU USED A NON-NETWORK PROVIDER. WE USED A NETWORK FEE BECAUSE YOU USED A NETWORK PROVIDER. YOUR BENEFITS ARE LOWER, HOWEVER, BECAUSE, ACCORDING TO OUR RECORDS, WE DID NOT RECEIVE NOTIFICATION FOR THIS SERVICE. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. YOU ARE, HOWEVER, RESPONSIBLE FOR THE DEDUCTIBLE AND THE COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	PR	62
D7	THIS EXPENSE HAS BEEN REVIEWED BY VALUEOPTIONS. ANY QUESTIONS REGARDING COVERED EXPENSES SHOULD BE REFERRED TO 1-800-525-9017.	CO	B11
D8	THIS CLAIM HAS BEEN INCORRECTLY SUBMITTED TO THE MEMBER'S MEDICAL CLAIM OFFICE. THIS AND ANY FUTURE CLAIMS FOR MENTAL HEALTH/ SUBSTANCE ABUSE SHOULD BE SENT DIRECTLY TO: PREFERRED MENTAL HEALTH MANAGEMENT, INC., 401 EAST DOUGLAS, SUITE 300, WICHITA, KS, 67202. THE TELEPHONE NUMBER IS 1-800-776-4357.	CO	109
D9	PLEASE HAVE THE HOSPITAL SEND THESE CHARGES TO BLUE CROSS FOR PAYMENT.	PR	109
EA	ACCORDING TO YOUR PLAN, YOU MUST RECEIVE TREATMENT FOR AN ACCIDENT WITHIN 72 HOURS. WE DID NOT RECEIVE INFORMATION TO INDICATE THAT TREATMENT WAS RECEIVED WITHIN 72 HOURS. IF YOU HAVE ADDITIONAL INFORMATION, PLEASE SUBMIT IT.	OA	17
EB	YOUR PLAN COVERS THE ACTUAL COST OF REASONABLE CHARGES FOR COVERED SERVICES. THIS PHYSICIAN OR PROVIDER WAIVES COPAY, COINSURANCE AND/OR DEDUCTIBLE AMOUNTS. WE HAVE DEDUCTED THESE FROM THE CHARGED AMOUNT TO DETERMINE THE ACTUAL COST OF THE SERVICE.	CO	42
EC	ACCORDING TO YOUR PLAN, WE HAVE APPLIED THE MAXIMUM ALLOWED EXPENSE FOR THE PRIMARY PROCEDURE. FOR EACH SUBSEQUENT PROCEDURE, WE HAVE APPLIED A PORTION OF THE ALLOWED AMOUNT.	CO	59
ED	ACCORDING TO YOUR PLAN, ALL CLAIMS FOR THESE SERVICES SHOULD BE SENT DIRECTLY TO CONNECTICUT GENERAL, P.O. BOX 5132, SOUTHFIELD, MI 48086.	OA	109
EE	YOUR PLAN DOES NOT COVER THIS MEDICAL SUPPLY, PROSTHETIC, ORTHOTIC APPLIANCE, OR DURABLE MEDICAL EQUIPMENT.	PR	96
EF	PLEASE CONTACT YOUR HUMAN RESOURCES DEPARTMENT IMMEDIATELY TO ENROLL YOUR NEWBORN CHILD. ACCORDING TO YOUR PLAN, YOUR NEWBORN CHILD WILL NOT HAVE INSURANCE COVERAGE UNTIL YOU HAVE ENROLLED THAT CHILD. ONCE YOU RECEIVE CONFIRMATION FROM YOUR EMPLOYER THAT YOUR NEWBORN HAS BEEN ADDED AS A COVERED DEPENDENT, PLEASE RETURN THIS STATEMENT TO THE ADDRESS SHOWN AT THE TOP AND WE WILL RECONSIDER THE CLAIM.	PR	32
EG	ACCORDING TO YOUR PLAN, ALLERGY TESTING AND TREATMENT, AND ALLERGY VACCINES ARE NOT COVERED.	PR	96
EH	YOUR PLAN DOES NOT COVER TRAVEL OR TRANSPORTATION EXPENSES, EVEN THOUGH IT MAY HAVE BEEN PRESCRIBED BY A PHYSICIAN.	PR	96
EI	ACCORDING TO YOUR PLAN, THIS LABORATORY/PATHOLOGY SERVICE IS NOT COVERED.	PR	96
EL	THIS EXPENSE EXCEEDS YOUR BENEFIT YEAR CHIROPRACTIC MAXIMUM.	PR	119
EM	THE SUBMITTED BILL CANNOT BE CONSIDERED WITHOUT A DIAGNOSIS. PLEASE RESUBMIT AN ITEMIZED BILL WITH A DIAGNOSIS.	OA	D21
EN	THIS CLAIM HAS BEEN SUBMITTED TO THE INCORRECT OFFICE. CLAIMS FOR THIS PATIENT MUST BE SUBMITTED TO OUR OFFICE THROUGH THE POMAC NETWORK. PLEASE SUBMIT THIS CLAIM AND FUTURE CLAIMS TO POMAC NETWORK AT THE FOLLOWING ADDRESS: 27 BLACKSMITH ROAD, SUITE 202, NEWTOWN, PA 18940.	PR	96
EO	YOUR PLAN DOES NOT COVER THIS GROWTH HORMONE SERVICE OR ASSOCIATED EXPENSE.	PR	96
EP	THE NOT COVERED AMOUNT REPRESENTS THE DISCOUNT ALLOWED BY THIS PROVIDER.	OA	131
ER	YOUR PLAN DOES NOT COVER SERVICES FOR THE TREATMENT OF MILITARY SERVICE-RELATED DISABILITIES WHEN THE COVERED PERSON IS LEGALLY ENTITLED TO OTHER COVERAGE AND FACILITIES ARE AVAILABLE.	PR	96
ES	BASED ON THE INFORMATION PROVIDED, THIS SERVICE DOES NOT MEET COVERAGE REQUIREMENTS AS DEFINED IN YOUR PLAN. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT MEDICAL RECORDS THAT DEMONSTRATE A PHYSIOLOGICAL FUNCTIONAL IMPAIRMENT, ALONG WITH AN EXPLANATION SHOWING HOW THIS SERVICE IMPROVES OR RESOLVES SUCH FUNCTIONAL IMPAIRMENTS AND MEETS THE REQUIREMENTS INDICATED IN YOUR BENEFIT PLAN LANGUAGE.	PR	50
ET	PSYCHIATRIC (MENTAL/NERVOUS) BENEFITS ARE BASED ON THE SERVICES PROVIDED, NOT JUST THE SUBMITTED DIAGNOSIS.	PR	122

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EV	YOUR PLAN DOES NOT COVER CUSTODIAL SERVICES OR SUPPLIES. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT MEDICAL DOCUMENTATION, ALONG WITH AN EXPLANATION THAT DEMONSTRATES THAT THIS SERVICE DOES NOT MEET YOUR PLAN'S DEFINITION OF CUSTODIAL SERVICES OR SUPPLIES.	PR	96
EW	YOUR CLAIM WAS NOT SUBMITTED WITHIN THE TIME FRAME SPECIFIED IN YOUR PLAN DOCUMENTS OR CONTRACT. CONSEQUENTLY, WE ARE UNABLE TO CONSIDER IT FOR PAYMENT. PLEASE REFER TO YOUR PLAN DOCUMENT OR CONTRACT SPECIFIC REQUIREMENTS FOR ADDITIONAL INFORMATION ON PERMISSIBLE TIMEFRAMES FOR SUBMITTING CLAIMS.	CO	29
EX	WORK HARDENING DOES NOT QUALIFY AS A COVERED EXPENSE UNDER THE PLAN BECAUSE IT IS NOT THERAPEUTIC TREATMENT OF AN INJURY OR SICKNESS.	PR	96
EY	ACCORDING TO YOUR PLAN, ONLY EXPENSES INCURRED DURING THE CURRENT YEAR AND THE TWO PRIOR YEARS CAN BE CONSIDERED FOR PAYMENT.	OA	29
EZ	THESE CHARGES ARE DENIED BECAUSE WE DID NOT RECEIVED INFORMATION REQUESTED FROM THE PATIENT.	OA	17
E0	THIS EXTRASPINAL MANIPULATION WAS PERFORMED IN CONJUNCTION WITH A SPINAL MANIPULATION REQUIRING INCLUSION OF A 51 MODIFIER. PAYMENT WAS MADE AT THE MODIFIER RATE.	CO	42
E1	WE ARE UNABLE TO CONSIDER THESE EXPENSES UNTIL SERVICES HAVE BEEN PERFORMED. PLEASE RESUBMIT THIS BILL AT THAT TIME.	OA	110
E2	THE MAXIMUM BENEFITS UNDER THIS PLAN HAVE BEEN EXHAUSTED.	PR	35
E3	PLEASE SUBMIT THESE BILLS TO YOUR HOSPITAL ASSOCIATION. THIS POLICY PROVIDES COVERAGE FOR YOUR DEPENDENTS ONLY.	OA	109
E4	BEFORE WE WILL BE ABLE TO CONSIDER THESE CHARGES, WE WILL NEED A COPY OF THE ITEMIZED BILL YOU SENT TO YOUR PRIMARY INSURANCE CARRIER. PLEASE ATTACH THE ITEMIZED BILL TO THIS EXPLANATION OF BENEFITS STATEMENT AND RETURN IT TO US FOR PROCESSING.	OA	16
E5	ADDITIONAL CHARGES AND/OR CORRECTED BILLING HAS BEEN CONSIDERED.		
E6	PLEASE HAVE THE PROVIDER SUBMIT DETAILED MEDICAL INFORMATION REGARDING THIS SERVICE, TREATMENT OR SUPPLY.	OA	16
E7	OUR RECORDS INDICATE THAT OUR RAILROAD EMPLOYEE IS NOT WORKING DUE TO A DISABILITY (INJURY/ILLNESS). CLAIMS FOR DEPENDENTS CANNOT BE PROCESSED UNTIL WE HAVE RECEIVED PROOF OF DISABILITY FROM THE RAILROAD EMPLOYEE'S ATTENDING PHYSICIAN.	OA	16
E8	COVERAGE WAS NOT IN EFFECT ON THE DATE OF THE ACCIDENT, THEREFORE, EXPENSES INCURRED AS A RESULT OF THE ACCIDENT ARE NOT PAYABLE.	OA	26
FA	BASED ON THE INFORMATION PROVIDED, THIS SERVICE IS UNPROVEN AND IS NOT COVERED. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT SCIENTIFIC EVIDENCE, THAT MEETS THE STANDARDS DESCRIBED IN YOUR BENEFIT PLAN LANGUAGE, THAT DEMONSTRATES THE SAFETY AND EFFECTIVENESS OF THIS SERVICE FOR YOUR PARTICULAR CONDITION.	PR	56
FB	THIS CLAIM WAS PROCESSED UNDER YOUR PRESCRIPTION DRUG PLAN. THE PHARMACY EXPENSE HAS BEEN APPLIED TOWARD YOUR COMBINED MEDICAL AND PHARMACY DEDUCTIBLE AND/OR OUT-OF-POCKET MAXIMUM. IF YOU HAVE QUESTIONS RELATED TO THIS PHARMACY CLAIM, PLEASE CONTACT YOUR PRESCRIPTION DRUG BENEFIT ADMINISTRATOR.		
FC	THIS PATIENT IS COVERED UNDER A SELF-INSURED BENEFIT PLAN. THEREFORE, THIS STAY IS NOT SUBJECT TO THE ELEVEN PERCENT (11%) NEW YORK HOSPITAL SURCHARGE. THE SURCHARGE HAS BEEN DEDUCTED FROM THE BILLED CHARGE. THE REMAINDER IS THE AMOUNT USED IN THIS BENEFIT CALCULATION. NEITHER THE PATIENT NOR THE BENEFIT PLAN ARE RESPONSIBLE TO THE HOSPITAL FOR THE 11% NEW YORK HOSPITAL SURCHARGE.	OA	45
FF	WE HAVE PAID THE MAXIMUM ALLOWED FOR THIS SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THE BALANCE OF CHARGES.	CO	35
FI	THIS PATIENT IS COVERED UNDER AND ERISA SELF-INSURED BENEFIT PLAN. THEREFORE, THIS STAY IS NOT SUBJECT TO NEW YORK HOSPITAL SURCHARGES. THESE SURCHARGES HAVE BEEN DEDUCTED FROM THE BILLED CHARGE. THE REMAINDER IS THE AMOUNT USED IN THIS BENEFIT CALCULATION.	OA	45
FJ	THE PATIENT IS NOT RESPONSIBLE FOR THE NOT COVERED AMOUNT. THIS AMOUNT IS A SERVICE CHARGE THAT IS IMPOSED BY STATE LAW. THE FEDERAL ERISA LAW PREVENTS THIS AMOUNT FROM BEING CHARGED TO THE PATIENT UNDER THIS SELF-INSURED PLAN.	OA	45
FK			
FM	THIS DENTAL EXPENSE IS NOT COVERED UNDER THIS GROUP HEALTH PLAN. WE HAVE FORWARDED THE CLAIM TO YOUR DENTAL CARRIER. TO AVOID	CO	96

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	DELAYS, PLEASE SUBMIT FUTURE DENTAL CLAIMS TO: UNITED HEALTHCARE P.O. BOX 30527 TAMPA, FL 33630		
FN	PAYMENT HAS BEEN MADE ACCORDING TO THE VALUE BEHAVIORAL HEALTH FEE SCHEDULE BECAUSE A NETWORK HEALTH CARE PROVIDER WAS USED. ALL COPAYS FOR THIS CLAIM HAVE BEEN DEDUCTED FROM THE ALLOWABLE AMOUNT FOR THE FIRST DATE OF SERVICE.	CO	A2
FO	ACCORDING TO OUR RECORDS, THE MAXIMUM NUMBER OF VISITS INDICATED DURING THE NOTIFICATION PROCESS HAS BEEN REACHED.	PR	62
FP	THE FACILITY'S DAILY RATE INCLUDES THESE CHARGES. THE PATIENT IS NOT RESPONSIBLE FOR THESE CHARGES.	PR	97
FQ	ACCORDING TO OUR RECORDS, A NOTIFICATION WAS NOT RECEIVED FOR THESE SERVICES AND THE SERVICES WERE RENDERED BY A NON-NETWORK PROVIDER. THEREFORE, IN ACCORDANCE WITH YOUR BENEFIT PLAN, YOUR BENEFITS HAVE BEEN REDUCED.	PR	62
FS	AN ANCHOR GROUP PSYCHIATRIST WAS NOT USED. THEREFORE, IN ACCORDANCE WITH YOUR BENEFIT PLAN, OUT-OF-NETWORK BENEFITS ARE BEING APPLIED.	CO	38
FT	PAYMENT REFLECTS VALUEOPTIONS'S CONTRACTED DAILY PROGRAM RATE. THE HEALTH CARE PROVIDER HAS AGREED TO ACCEPT THE FEE AS FULL PAYMENT.	CO	A2
FV	ACCORDING TO OUR RECORDS, AN OUT-OF-NETWORK HEALTH CARE PROVIDER WAS USED. PAYMENT HAS BEEN MADE ACCORDING TO THE VALUE BEHAVIORAL FEE SCHEDULE.	CO	38
FW	AN OUT-OF-NETWORK PROVIDER FURNISHED THESE SERVICES. YOUR HEALTH PLAN PROVIDES A LOWER LEVEL OF BENEFITS FOR OUT-OF-NETWORK SERVICES.	PR	38
FX	ACCORDING TO OUR RECORDS, WE PREVIOUSLY PAID THIS HEALTH CARE PROVIDER FOR AN EVALUATION SESSION FOR THIS MEMBER.	PR	B13
FY	ACCORDING TO YOUR PLAN, NOTIFICATION IS REQUIRED FOR THIS SERVICE.	CO	62
FZ	COVERAGE, FOR THIS SERVICE, WAS NOT GRANTED FOR THIS HEALTH CARE PROVIDER.	PR	170
F0	THE ENCLOSED CHECK IS IN RECOGNITION OF THE IMPROPER BILLING NOTIFICATION YOU PROVIDED TO US.	CR	125
F1	ACCORDING TO YOUR PLAN, THIS DEPENDENT DOES NOT QUALIFY FOR COVERAGE FOR THIS CONDITION.	PR	167
F2	THE PATIENT'S CONTRACT DOES NOT COVER THIS FOOT OR ANKLE SERVICE. ACCORDING TO THE PATIENT'S BENEFIT PLAN, COVERAGE FOR FOOT AND ANKLE BENEFITS ARE FOR AMPUTATIONS AND CARE OF ACCIDENTAL INJURIES. IN ORDER FOR THIS CLAIM TO BE CONSIDERED, PLEASE SUBMIT IT TO THE NATIONAL FOOT CARE PROGRAM HAVE QUESTIONS, PLEASE CALL THE NATIONAL FOOT CARE PROGRAM AT 1-800-922-1695.	OA	109
F3	ACCORDING TO YOUR PLAN, THE MAXIMUM BENEFIT FOR THIS CONDITION IS \$40.00 PER TREATMENT.	PR	35
F4	A MAXIMUM OF 30 VISITS MAY BE PAID FOR THIS CONDITION DURING A 12-MONTH BENEFIT PERIOD.	PR	119
F5	ACCORDING TO OUR RECORDS, YOU HAVE REACHED THE MAXIMUM BENEFIT AMOUNT BASED ON THE PROVISIONS REQUIRED UNDER STATE MANDATED BENEFITS. THEREFORE NO ADDITIONAL BENEFITS ARE PAYABLE.	PR	119
F6	YOUR PLAN DOES NOT COVER PRESCRIPTION MEDICATIONS FOR OUTPATIENT TREATMENT.	PR	96
F7	THESE MEDICAL EXPENSES HAVE BEEN CONVERTED TO US DOLLARS USING THE EXCHANGE RATE ON THE ACTUAL DATE OF SERVICE.		
F8	THE COMBINATION OF YOUR PRIMARY CARRIER'S BENEFITS AND OUR BENEFITS AVAILABLE FOR THE ABOVE EXPENSES EXCEEDS THE TOTAL CHARGE. SINCE YOU HAD PREVIOUSLY INCURRED A REMAINING EXPENSE FOR THIS CALENDAR YEAR, THE EXCESS HAS BEEN APPLIED TOWARDS THOSE REMAINING EXPENSES.	CO	22
F9	ACCORDING TO YOUR PLAN, YOUR LIFETIME MAXIMUM HAS BEEN MET WITH THIS PAYMENT.	PR	35
GA	ACCORDING TO YOUR CONTRACT, CLAIMS MUST BE SUBMITTED WITHIN THE TIMELY FILING LIMIT. AFTER REVIEWING YOUR APPEAL, IT WAS DETERMINED THAT THE INFORMATION SUBMITTED MEETS THE REQUIREMENTS. BENEFITS HAVE BEEN RECONSIDERED BASED ON THE MEMBER'S PLAN.		
GB	YOUR CLAIM HAS BEEN REPROCESSED BASED ON THE ADDITIONAL INFORMATION WE RECEIVED REGARDING THE DISCOUNT.		
GC	YOUR CLAIM HAS BEEN RECONSIDERED BASED ON ADDITIONAL INFORMATION		

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	FROM YOUR HOSPITAL PARTICIPATION AGREEMENT WITH UNITED RESOURCE NETWORKS.		
GD	THIS PAYMENT IS MADE ON AN EXCEPTION BASIS AS REIMBURSEMENT FOR A CARE COORDINATION PENALTY DEDUCTIBLE TAKEN AT AN EARLIER DATE.	PR	1
GE	THE NOT COVERED AMOUNT IS YOUR MEDICARE PART B DEDUCTIBLE PLUS THE DOLLAR AMOUNT THAT IS OVER MEDICARE'S ALLOWANCE. YOUR PLAN DOES NOT COVER CHARGES THAT WERE APPLIED TO THE MEDICARE PART B DEDUCTIBLE.	PR	23
GF	WE HAVE REPROCESSED YOUR CLAIM BASED ON THE ADDITIONAL INFORMATION WE RECEIVED REGARDING THE DISCOUNT.		
GG	THIS CLAIM HAS BEEN REDUCED IN WHOLE OR IN PART BASED ON THE SUBROGATION REVIEW BY COUGHLAN KUKANOS COOK, LLC. IF YOU HAVE ANY QUESTIONS, PLEASE CALL COUGHLAN KUKANOS COOK, LLC AT 1 (312) 357-9200. COUGHLAN KUKANOS COOK, LLC HAS BEEN RETAINED BY CHICAGO PUBLIC SCHOOLS AND IS NOT AFFILIATED WITH UNITEDHEALTHCARE.		
GI	YOUR HEALTH CARE PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. HOWEVER, YOU ARE RESPONSIBLE FOR DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	CO	131
GJ	WHILE YOUR CONTRACT INDICATES CLAIMS MUST BE SUBMITTED WITHIN THE TIMELY FILING LIMIT, YOUR REQUEST FOR A ONE-TIME EXCEPTION HAS BEEN REVIEWED AND APPROVED.		
GK	THESE CHARGES ARE FOR SERVICES PROVIDED AFTER THIS PATIENT'S COVERAGE WAS CANCELED, THEREFORE, THEY ARE NOT COVERED.	PR	27
GL	WE HAVE NOT RECEIVED VERIFICATION FROM YOUR EMPLOYER THAT THESE CHARGES ARE RELATED TO AN ON-DUTY INJURY. IF YOU RECEIVE THIS VERIFICATION, PLEASE ATTACH IT TO THIS EXPLANATION OF BENEFITS AND RETURN IT TO THE ABOVE ADDRESS.	PR	16
GM	THIS INDIVIDUAL IS NO LONGER COVERED UNDER THIS PLAN. THIS AND ANY FUTURE CLAIMS SHOULD BE MAILED TO: RAILROAD MEDICARE CLAIM OFFICE P.O. BOX 10066 AUGUSTA, GA 30999-0001 PHONE #: 706-855-1386	OA	27
GN	WE ASKED YOUR PROVIDER TO SEND US MORE INFORMATION. WE WILL PROCESS THE CLAIM WHEN WE RECEIVE THIS INFORMATION.	CO	17
GP	WE ASKED YOUR PROVIDER TO SEND US MORE INFORMATION. WE WILL PROCESS THE CLAIM WHEN WE RECEIVE THIS INFORMATION.	CO	17
GQ	ACCORDING TO YOUR PLAN, PERSPECTIVES MUST RECEIVE NOTIFICATION FOR SERVICES OF A SOCIAL WORKER IN ORDER TO BE CONSIDERED FOR REIMBURSEMENT.	PR	62
GR	ACCORDING TO YOUR PLAN, PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES NOT AUTHORIZED BY PERSPECTIVES ARE SUBJECT TO AN 8 VISIT CALENDAR YEAR MAXIMUM.	PR	122
GS	WE REVIEWED THE PROCEDURE CODE MODIFIER REPORTED FOR THIS CLAIM. CLAIM REIMBURSEMENT HAS BEEN ADJUSTED ACCORDINGLY.	CO	4
GT	THIS ADDITIONAL PAYMENT IS BEING ISSUED FROM ACCUMULATED SAVINGS DUE TO COORDINATION OF BENEFITS WITH MEDICARE.	CO	22
GV	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
GW	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
GX	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
GY	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
GZ	WE HAVE NOT RECEIVED ALL THE REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. PLEASE REFER TO OUR CORRESPONDENCE IDENTIFYING WHAT WE NEED SO WE CAN COMPLETE THE PROCESSING OF THIS CLAIM. THANK YOU	PR	17
G0	THE MAINE HEALTH CARE FINANCE COMMISSION HAS A REGULATION WHICH ALLOWS A DIFFERENTIAL FOR PROMPT PAYMENTS. BASED ON THIS REGULATION, A PROMPT PAYMENT DIFFERENTIAL HAS BEEN APPLIED TO THIS CLAIM. YOU ARE NOT RESPONSIBLE FOR PAYING THE DIFFERENTIAL AMOUNT.	OA	44
G2	ACCORDING TO YOUR PLAN, EXAMINATIONS AND TESTS IN CONNECTION WITH WEIGHT CONTROL PROGRAMS ARE NOT COVERED.	PR	96
G3	ACCORDING TO YOUR PLAN, THIS RADIOLOGY SERVICE IS NOT COVERED.	PR	96
G4	ACCORDING TO YOUR PLAN, ANESTHESIA ADMINISTERED IN CONNECTION WITH NON COVERED SURGERY IS NOT COVERED.	PR	96

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G5	ACCORDING TO YOUR PLAN, THIS CARDIAC REHABILITATION SERVICE IS NOT COVERED.	OA	96
G6	ACCORDING TO YOUR PLAN, ONLY EXPENSES COVERED BY MEDICARE PART B ARE COVERED BY YOUR PLAN.	PR	96
G7	THE BENEFIT FOR THESE SERVICES IS BASED ON THE DIFFERENCE BETWEEN MEDICARE'S ALLOWABLE EXPENSE AND THE AMOUNT MEDICARE PAID. PLEASE CALL MEDICARE IF YOU HAVE QUESTIONS WITH REGARDS TO MEDICARE ALLOWABLE EXPENSES. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	PR	96
G8	YOUR PLAN DOES NOT PROVIDE REIMBURSEMENT FOR MEDICARE PART A EXPENSES.	PR	
G9	PLEASE SUBMIT A COPY OF YOUR MEDICARE CARD SO WE CAN VERIFY THE EFFECTIVE DATE OF YOUR PART A AND PART B COVERAGE.	OA	16
HA	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REPROCESSED BASED ON INFORMATION RECEIVED FROM ADVANA.		
HB	THIS SERVICE OR SUPPLY IS PART OF A MAIN PROCEDURE AND IS NOT COVERED SEPARATELY.	CO	97
HC	A NEW, MORE ACCURATE PROCEDURE CODE HAS BEEN ASSIGNED FOR THIS SERVICE(S). WE HAVE REDUCED THE COVERED EXPENSE TO A REASONABLE CHARGE OR THE PROVIDER'S DISCOUNTED FEE.	CO	45
HD	WE RECEIVED ONE OR MORE PROCEDURE CODES TO REPRESENT THE SERVICES RECEIVED. WE USED A SINGLE PROCEDURE CODE THAT MORE APPROPRIATELY REPRESENTS THE SERVICES RECEIVED. YOUR PLAN BENEFITS WERE APPLIED USING THIS SINGLE PROCEDURE CODE.		
HF	WE TOOK INTO ACCOUNT THE MODIFYING CIRCUMSTANCES TO DETERMINE THE COVERED AMOUNT.	CO	42
HI	UNITEDHEALTHCARE RETAINS THE SERVICES OF ADVANA TO REVIEW CLAIMS WHEN THERE IS AN INDICATION THAT OTHER INSURANCE COVERAGE MAY BE AVAILABLE. THIS CLAIM HAS BEEN REPROCESSED BASED ON INFORMATION RECEIVED FROM ADVANA.		
HJ	ACCORDING TO YOUR PLAN, THERE IS A MAXIMUM NUMBER OF THESE SERVICES ALLOWED PER DAY. THE NUMBER OF SERVICES OVER THAT AMOUNT ARE NOT PAYABLE AT THIS TIME. IF YOUR DOCTOR SENDS US ADDITIONAL INFORMATION, WE WILL RE-EXAMINE THE CLAIM.	CO	119
HK	BASED ON THE INFORMATION WE RECEIVED, NOT ALL OF THE SERVICES PERFORMED BY THIS HEALTH CARE PROVIDER WERE COVERED SERVICES. THEREFORE, BENEFITS ARE NOT AVAILABLE.	PR	96
HL	A LETTER OF EXPLANATION WILL FOLLOW UNDER SEPARATE COVER.		
HM	WE HAVE PROCESSED THESE CHARGES USING A PROCEDURE CODE THAT MORE ACCURATELY DESCRIBES THE SERVICES PROVIDED.	CO	97
HN			
HO			
HP	THE INFORMATION PROVIDED DOES NOT CONTAIN SUFFICIENT DETAIL TO SUPPORT THE SERVICES BILLED.	CO	96
HQ	WE CANNOT PROCESS THIS CLAIM BECAUSE WE ARE UNABLE TO VERIFY THE INFORMATION SUBMITTED AND/OR ARE UNABLE TO VERIFY AN ACTIVE LICENSE FOR THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. PLEASE CONTACT OUR CUSTOMER CARE CENTER.	PR	17
HR	WE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF THE ADDITIONAL INFORMATION THAT WAS SUBMITTED.		
HS	THIS CLAIM IS BEING DENIED BECAUSE THE SUBMITTED MEDICAL INFORMATION IS INCOMPLETE.	PR	17
HT	THESE CHARGES ARE CONSIDERED AN INTEGRAL PART OF THE PRIMARY PROCEDURE AND NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT.	OA	B15
HU	THE DOCUMENTATION INDICATES THAT THE SERVICES WERE ADMINISTERED BY A HEALTH CARE PROVIDER OTHER THAN THE BILLING HEALTH CARE PROVIDER.	CO	B20
HV	THE ABOVE NAMED HEALTH CARE PROVIDER DOES NOT HAVE A RECORD OF PERFORMING THE SERVICE(S) BILLED. NO BENEFITS ARE PAYABLE AT THIS TIME.	CO	96
HW	NO DOCUMENTATION WAS SUBMITTED FOR THIS DATE OF SERVICE. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	17
HX	WE HAVE RECEIVED THE INFORMATION REQUESTED FROM THE PROVIDER(S) BUT NOT THE INFORMATION REQUESTED FROM THE PATIENT. THEREFORE, WE ARE DENYING THESE CHARGES.	PR	17
HY	THE MEDICAL DOCUMENTATION THAT WAS SUBMITTED WITH THIS CLAIM HAS BEEN FORWARDED FOR REVIEW. WE WILL PROCESS THIS CLAIM WHEN THE REVIEW HAS BEEN COMPLETED.	OA	133
HZ	YOUR PLAN COVERS REASONABLE CHARGES FOR THERAPEUTIC TREATMENT OF	CO	96

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H0	SICKNESS OR INJURY. THE REASONABLE CHARGE IS BASED ON AMOUNTS CHARGED BY OTHER PROVIDERS FOR SIMILAR SERVICES OR SUPPLIES. ACN GROUP RECEIVED THE HEALTH CARE PROVIDER'S NOTIFICATION FOR THIS DATE OR SERVICE SHOWN. WE WERE UNABLE TO APPROVE THIS SERVICE OR LENGTH OF TIME REQUESTED. PLEASE REFER TO OUR RESPONSE TO THE HEALTH CARE PROVIDER'S NOTIFICATION FOR AN EXPLANATION OF THE DENIAL. THE PATIENT MAY NOT BE BILED FOR AMOUNTS DECLINED WHEN ADMINISTRATIVE REQUIREMENTS ARE NOT FOLLOWED.	CO	62
H1			
H2			
H3	WE PROCESSED THIS EXPENSE USING THE HIGHER BENEFIT LEVEL BECAUSE YOU CONTACTED US. YOU ARE RESPONSIBLE FOR ANY COPAYMENT, COINSURANCE, OR DEDUCTIBLE AMOUNTS.	CO	131
H4	UNDER CONNECTICUT PUBLIC ACT 90-134, CONNECTICUT PHYSICIANS AND OTHER HEALTH CARE PROVIDERS MUST ACCEPT THE BENEFIT AMOUNT PAID AS FULL PAYMENT. CONNECTICUT PHYSICIANS AND OTHER HEALTH CARE PROVIDERS CANNOT BILL THE PATIENT ANY BALANCE ABOVE THE AMOUNT APPLIED TO THE DEDUCTIBLE. THE PATIENT IS NOT RESPONSIBLE FOR ANY PAYMENT ABOVE WHAT WAS APPLIED TO THE DEDUCTIBLE. IF NO DEDUCTIBLE WAS APPLIED THE PATIENT'S PORTION IS \$0.	OA	45
H5	YOUR BENEFITS HAVE BEEN DETERMINED IN ACCORDANCE WITH CONNECTICUT PUBLIC ACT 90-34.	OA	45
H6			
H7			
H8			
IA	THIS SERVICE WAS PERFORMED IN A FACILITY SETTING. THIS CODE, WHEN ACCOMPANIED BY A FACILITY PLACE OF SERVICE, IS NOT ELIGIBLE FOR REIMBURSEMENT TO THE PHYSICIAN.	CO	97
IB	THIS AMOUNT REPRESENTS A DEDUCTIBLE/OUT-OF-POCKET(OOP) CREDIT OR ROLLOVER APPLIED FROM A PREVIOUS PLAN. "CREDIT" REFERS TO THE AMOUNT OF DEDUCTIBLE/OOP ALREADY SATISFIED ON ANOTHER UNITEDHEALTH GROUP PLAN. "ROLLOVER" REFERS TO THE AMOUNT OF DEDUCTIBLE/OOP ALREADY SATISFIED ON A PLAN ADMINISTERED BY AN EXTERNAL CARRIER.		
IC	AN INVOICE COST WAS NOT SHOWN IN THE VALUE CODE FIELD. THEREFORE, THESE SERVICES HAVE BEEN CONSIDERED AS PART OF THE MISCELLANEOUS CHARGES. FOR ADDITIONAL REIMBURSEMENT CONSIDERATION, PLEASE RESUBMIT THIS CLAIM ALONG WITH THE MANUFACTURER'S INVOICE COST AND THE CODE AB IN THE VALUE CODE FIELD.	CO	45
ID	THIS CHARGE CANNOT BE PAID. THE ANESTHESIA FEE CONSIDERED FOR THIS PATIENT INCLUDES ALL SERVICES NORMALLY ASSOCIATED WITH THE DELIVERY OF ANESTHESIA.	CO	97
IE	THIS CHARGE CANNOT BE PAID. THE CLAIM REIMBURSEMENT FOR THE DELIVERY OF ANESTHESIA IS BASED ON ONLY ONE OF THE PROCEDURE CODES SUBMITTED.	CO	97
IF	THE INVOICE COST SHOWN IN THE VALUE CODE FIELD DID NOT EXCEED THE CONTRACTED THRESHOLD AMOUNT. THEREFORE, THESE SERVICES HAVE BEEN CONSIDERED AS PART OF THE MISCELLANEOUS CHARGES.	CO	45
IG	WE HAVE ALREADY CONSIDERED AN ANESTHESIA DELIVERY SERVICE FOR THIS PATIENT ON THIS DATE OF SERVICE. CLAIM REIMBURSEMENT FOR THE DELIVERY OF ANESTHESIA IS BASED ON ONLY ONE OF THE PROCEDURE CODES SUBMITTED. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS SERVICE.	CO	18
IH	WE HAVE ASSIGNED THE MOST APPROPRIATE PROCEDURE CODE MODIFIER FOR THIS CLAIM BASED ON THE OTHER CLAIMS PROCESSED FOR THIS PATIENT. WE HAVE BASED CLAIM REIMBURSEMENT ON THE PROCEDURE CODE MODIFIER ASSIGNED.		
II			
IJ	THE NUMBER OF UNITS BILLED FOR THIS SERVICE APPEARS TO BE INCORRECT. IT EXCEEDS THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE. WE'VE ADJUSTED THE UNITS FOR THIS PROCEDURE CODE AND CHARGE.	CO	151
IK	THIS SERVICE REPLACED A SERVICE THAT WAS BILLED WITH UNITS OVER THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE. THIS SERVICE USES THE SAME PROCEDURE CODE AS THE ORIGINAL BUT ASSUMES THAT THE NUMBER OF UNITS IS THE TYPICAL FREQUENCY PER DAY. THE BENEFITS ARE BASED ON THIS QUANTITY.		
IN	YOUR HEALTH CARE PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ACCEPTED BY THE PROVIDER. HOWEVER, YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	OA	A2
IM	WE WILL CONTINUE TO PROVIDE NETWORK LEVEL BENEFITS RELATED TO THIS		

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	PREGNANCY TO THIS PROVIDER. HOWEVER, ANY FUTURE CHARGES FROM THIS PROVIDER NOT RELATED TO THIS PREGNANCY WILL BE COVERED AT THE LOWER LEVEL OF BENEFITS.		
IO	THIS SERVICE IS BEING RECODED TO REVISE THE PROCEDURE CODE AND CHARGE.	CO	B15
IP	WE ARE SENDING YOU A QUESTIONNAIRE THAT NEEDS TO BE COMPLETED AND RETURNED BEFORE WE CAN CONSIDER THIS CLAIM FOR PAYMENT.	PR	16
IQ	THIS AMOUNT REPRESENTS AN ADDITIONAL BILLING. AFTER REVIEWING THIS ACCOUNT, WE HAVE FOUND THAT THERE IS NO BALANCE DUE.	PR	96
IR	THIS SERVICE REPLACES A SERVICE BILLED INAPPROPRIATELY AS A NEW PATIENT VISIT. OUR RECORDS SHOW THAT THERE HAS BEEN A PREVIOUS VISIT AND WE HAVE CHANGED THE PROCEDURE CODE TO REFLECT AN ESTABLISHED PATIENT VISIT.		
IS	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A REDUCTION IN CHARGES ON THIS CLAIM THROUGH	CO	A2
	AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.		
IT	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN ACCORDANCE WITH HIS OR HER MULTIPLAN AGREEMENT. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.	CO	A2
IU	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN	CO	A2
	RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.		
IV	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN	CO	A2
	YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.		
IW	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN	CO	A2
	ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.		
IX	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A REDUCTION IN CHARGES ON THIS CLAIM THROUGH MULTIPLAN. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROFESSIONAL FOR A REFUND.	CO	A2
IY	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN	CO	A2
	AGREEMENT. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.		
IZ	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN	CO	A2

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	ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.		
10	THESE SERVICES ARE NOT ELIGIBLE FOR A TEAM SURGEON	OA	54
11	THE PROCEDURE CODE SUBMITTED IS NOT CONSIDERED REIMBURSABLE AS BILATERAL.	OA	96
12	THESE SERVICES ARE NOT ELIGIBLE FOR A CO-SURGEON.	OA	54
13	THIS SERVICE IS NOT COVERED FOR THIS PROVIDER SPECIALTY.	OA	172
14	THIS IS NOT A SEPARATELY REIMBURSABLE SERVICE OR SUPPLY. SUPPLY CODES SHOULD BE SUBMITTED WITH HCPCS CODES.	CO	97
15	THIS SERVICE CODE IS NOT SEPARATELY REIMBURSABLE IN THIS SETTING.	OA	B15
16	ACCORDING TO OUR RECORDS, A NETWORK PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL WAS USED. UNDER THE PLAN, NOTIFICATION WAS REQUIRED BUT NOT RECEIVED. THEREFORE, WE HAVE DECLINED PAYMENT FOR THE SERVICE BECAUSE REQUIREMENTS OF THE PLAN WERE NOT MET. ACCORDING TO THE NETWORK CONTRACT, THE PATIENT MAY NOT BE BILLED FOR THE DECLINED AMOUNT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR THE NETWORK PLAN COPAY, DEDUCTIBLE, OR COINSURANCE AMOUNTS.	CO	62
17	ACCORDING TO OUR RECORDS, A NETWORK PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL WAS USED. UNDER THE PLAN, NOTIFICATION WAS REQUIRED BUT NOT RECEIVED. THEREFORE, WE HAVE DECLINED PAYMENT FOR THE SERVICE BECAUSE REQUIREMENTS OF THE PLAN WERE NOT MET. ACCORDING TO THE NETWORK CONTRACT, THE PATIENT MAY NOT BE BILLED FOR THE DECLINED AMOUNT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR THE NETWORK PLAN COPAY, DEDUCTIBLE, OR COINSURANCE AMOUNTS.	CO	62
18	ACCORDING TO OUR RECORDS, A NETWORK HEALTHCARE FACILITY WAS USED. UNDER THE PLAN, NOTIFICATION WAS REQUIRED BUT NOT RECEIVED. THEREFORE, WE HAVE DECLINED PAYMENT FOR THE SERVICE BECAUSE REQUIREMENTS OF THE PLAN WERE NOT MET. ACCORDING TO THE NETWORK CONTRACT, THE PATIENT MAY NOT BE BILLED FOR THE DECLINED AMOUNT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR THE NETWORK PLAN COPAY, DEDUCTIBLE, OR COINSURANCE AMOUNTS.	CO	62
19	ACCORDING TO OUR RECORDS, A NETWORK HEALTHCARE FACILITY WAS USED. UNDER THE PLAN, NOTIFICATION WAS REQUIRED BUT NOT RECEIVED. THEREFORE, WE HAVE DECLINED PAYMENT FOR THE SERVICE BECAUSE REQUIREMENTS OF THE PLAN WERE NOT MET. ACCORDING TO THE NETWORK CONTRACT, THE PATIENT MAY NOT BE BILLED FOR THE DECLINED AMOUNT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR THE NETWORK PLAN COPAY, DEDUCTIBLE, OR COINSURANCE AMOUNTS.	CO	62
JA	WE RECEIVED THE INFORMATION REQUESTED FROM THE PROVIDER(S). HOWEVER, THESE CHARGES CANNOT BE CONSIDERED UNTIL WE HAVE RECEIVED THE INFORMATION REQUESTED FROM THE EMPLOYEE.	OA	17
JB	WE RECEIVED YOUR CLAIM AND ARE UNABLE TO PROCESS IT AT THIS TIME. PLEASE REFER TO OUR LETTER DESCRIBING THE ADDITIONAL INFORMATION WE NEED TO PROCESS YOUR CLAIM.	PR	51
JC	THIS CHARGE HAS BEEN DENIED BECAUSE THERE IS NO REFERRAL OR AUTHORIZATION FOR THE PARTICIPATING HEALTH CARE PROVIDER TO PROVIDE THIS SERVICE. SINCE THERE IS AN ACCEPTABLE ENROLLEE WAIVER OR POS ELECTION FORM ON FILE, THIS MEANS THE ENROLLEE HAS ACCEPTED FINANCIAL RESPONSIBILITY FOR THIS EXPENSE.	PR	62
JD	THIS CHARGE HAS BEEN DENIED BECAUSE THE HEALTH CARE PROVIDER DID NOT FILE THE CLAIM WITHIN THE CONTRACTED FILING PERIOD. SINCE THERE IS AN ACCEPTABLE ENROLLEE WAIVER OR POS ELECTION FORM ON FILE, THIS MEANS THE ENROLLEE HAS ACCEPTED FINANCIAL RESPONSIBILITY FOR THIS EXPENSE.	PR	29
JE	YOUR GROUP HEALTH PLAN CONTAINS A PRE-EXISTING CONDITION LIMITATION. ACCORDING TO OUR RECORDS, THESE EXPENSES RELATE TO A CONDITION THAT FALLS UNDER THE PRE-EXISTING CONDITION LIMITATION. THEREFORE, NO COMPREHENSIVE OR MAJOR MEDICAL BENEFITS ARE AVAILABLE AT THIS TIME.	PR	51
JF	PREVIOUSLY THIS CHARGE WAS DENIED AND THE HEALTH CARE PROVIDER HELD LIABLE FOR THE EXPENSE BECAUSE OF NO REFERRAL OR AUTHORIZATION TO PROVIDE SERVICES. SINCE AN ACCEPTABLE ENROLLEE WAIVER OR POS ELECTION FORM WAS RECEIVED DURING THE APPEAL PROCESS, THE HEALTH CARE PROVIDER IS NO LONGER LIABLE. THE ENROLLEE IS RESPONSIBLE FOR THESE CHARGES.	PR	62
JG	PREVIOUSLY THIS CHARGE WAS DENIED AND THE HEALTH CARE PROVIDER HELD LIABLE FOR THE EXPENSE BECAUSE OF UNTIMELY FILING. SINCE AN ACCEPTABLE ENROLLEE WAIVER OR POS ELECTION FORM WAS RECEIVED DURING THE APPEAL	PR	29

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	PROCESS, THE HEALTH CARE PROVIDER IS NO LONGER LIABLE. THE ENROLLEE IS RESPONSIBLE FOR THESE CHARGES.		
JH	PREVIOUSLY THIS CHARGE WAS DENIED AND THE HEALTH CARE PROVIDER HELD LIABLE FOR THE EXPENSE. DURING THE APPEAL PROCESS, AN ENROLLEE WAIVER OR POS ELECTION FORM WAS RECEIVED, BUT DID NOT MEET THE CRITERIA AS BEING ACCEPTABLE. THIS MEANS THE HEALTH CARE PROVIDER IS STILL LIABLE FOR THIS EXPENSE AND THAT THE ENROLLEE IS NOT RESPONSIBLE FOR THESE CHARGES.		
JJ	ACCORDING TO OUR RECORDS, THIS EXPENSE WAS NOT PREVIOUSLY COVERED DUE TO YOUR PLAN'S PRE-EXISTING LIMITATION PROVISION. WE HAVE RECEIVED ADDITIONAL INFORMATION AND ARE RECONSIDERING THIS CLAIM.		
JL	YOUR SUPPLEMENTAL EXECUTIVE PLAN HAS A VISION BENEFIT LIMIT. PAYMENT HAS BEEN MADE BASED ON THAT LIMIT.	CO	119
JM	OUR RECORDS SHOW THAT YOUR PLAN'S MAXIMUM YEARLY BENEFIT FOR THIS SERVICE OR TREATMENT HAS BEEN PAID. THEREFORE, NO ADDITIONAL BENEFITS ARE PAYABLE FOR THIS CALENDAR YEAR.	PR	119
JN	ACCORDING TO OUR RECORDS, THE MAXIMUM BENEFIT AMOUNT FOR PRESCRIPTION DRUGS HAS BEEN PAID FOR THE CALENDAR YEAR.	PR	119
JO	YOUR SUPPLEMENTAL EXECUTIVE PLAN HAS A DENTAL BENEFIT LIMIT. PAYMENT HAS BEEN MADE BASED ON THAT LIMIT.	CO	119
JP	NOTE TO ENROLLEE: PLEASE SUBMIT CURRENT COORDINATION OF BENEFIT INFORMATION BY CONTACTING US THROUGH MYUHC.COM, OR CALLING THE NUMBER ON YOUR ID CARD.	OA	16
JQ	IN ORDER FOR US TO MAKE AN ADJUSTMENT TO A PREVIOUS PAYMENT, WE MUST RECEIVE THE CORRECTIVE ADJUSTMENT REQUEST WITHIN THE TIME FRAME INDICATED IN YOUR CONTRACT. NO ADDITIONAL PAYMENT IS DUE.	OA	138
JR	YOUR PLAN DOES NOT COVER OUTPATIENT PRESCRIBED OR NON-PRESCRIBED MEDICAL SUPPLIES.	PR	96
JS	WE CAN ONLY ACCEPT CLAIMS THAT ARE SENT BY THE CONTRACTED PHYSICIAN OR PROVIDER. THIS CLAIM WAS SENT DIRECTLY TO UNITEDHEALTHCARE IN ERROR. THIS AND ANY FUTURE CLAIMS SHOULD BE SENT TO US BY THE CONTRACTED PHYSICIAN OR PROVIDER.	PR	109
JT	SERVICES RENDERED BY NON NETWORK PROVIDERS ARE GENERALLY NOT ELIGIBLE FOR PAYMENT. THIS CLAIM HAS BEEN PAID AS AN EXCEPTION AND AT THE HIGHEST BENEFIT LEVEL AVAILABLE.		
JV	YOU HAVE USED ALL OF THE BENEFITS AVAILABLE FOR THESE SERVICES. YOU ARE RESPONSIBLE FOR THE PATIENT PAYS.	PR	35
JW	FEDERAL LAWS LIMIT HOW MUCH THE PROVIDER MAY BILL FOR THE SERVICE(S) PERFORMED. WE EXCLUDED THE AMOUNT THAT WE BELIEVE THE PATIENT IS NOT REQUIRED TO PAY.	OA	96
JX	THIS PLAN IS SECONDARY TO MEDICARE. PLEASE SUBMIT THIS CLAIM TO MEDICARE PROCESSING.	CO	22
JY	THE MAXIMUM BENEFITS UNDER THIS SUPPLEMENTAL EXECUTIVE PLAN HAVE BEEN EXHAUSTED.	PR	119
JZ	ACCORDING TO OUR RECORDS, THE REVIEW PROGRAM DID NOT RECEIVE NOTIFICATION FOR THIS SERVICE. THEREFORE, NO BENEFITS ARE AVAILABLE. YOU ARE RESPONSIBLE FOR THE PAYMENT.	PR	62
J0	WE WERE UNABLE TO PROCESS THIS SERVICE BECAUSE ACN GROUP DID NOT RECEIVE THE REQUIRED CLINICAL NOTIFICATION FROM THE HEALTH CARE PROVIDER. THE PATIENT MAY NOT BE BILLED FOR AMOUNTS DECLINED WHEN ADMINISTRATIVE REQUIREMENTS ARE NOT FOLLOWED.	CO	62
J1	PAYMENT WAS MADE TO THE PHYSICIAN IN CHARGE FOR THIS PERIOD OF CONFINEMENT. MEDICAL CARE GIVEN BY ANOTHER PHYSICIAN(S) FOR THE SAME CONDITION DURING THE SAME CONFINEMENT PERIOD IS NOT COVERED BY YOUR PLAN.	PR	B20
J2	ACCORDING TO YOUR PLAN, MANIPULATIONS ARE NOT COVERED.	PR	96
J3	FOR THIS SERVICE TO BE CONSIDERED UNDER YOUR SUPPLEMENTAL EXECUTIVE PLAN, WE REQUIRE AN EXPLANATION OF BENEFITS FROM YOUR OTHER BENEFIT PLAN. PLEASE SEND US THE EXPLANATION OF BENEFITS AT THE ADDRESS SHOWN ABOVE.	CO	16
J5	THIS SERVICE WAS PAID IN FULL UNDER YOUR GROUP DENTAL PLAN. NO PAYMENT IS AVAILABLE FROM THE SUPPLEMENTAL EXECUTIVE PLAN.	CO	96
J6	THIS CLAIM IS A PRE-TREATMENT ESTIMATE. BENEFITS ARE ONLY AVAILABLE AFER SERVICES ARE PROVIDED.	CO	101
J7	THERE IS NO PATIENT LIABILITY ON THIS CLAIM. THEREFORE, THERE ARE NO BENEFITS PAYABLE UNDER THE SUPPLEMENTAL EXECUTIVE PLAN.	CO	96
J8	THE PROCEDURE CODE SUBMITTED IS NOT ELIGIBLE FOR PAYMENT FOR THIS PHYSICIAN OR HEALTH CARE PROFESSIONAL BECAUSE SERVICES WERE PERFORMED IN AN OFFICE OR OUTPATIENT SETTING, AND IS NOT ON THE LIST OF	CO	96

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	REIMBURSABLE SERVICES. ACCORDING TO THE NETWORK CONTRACT, THE PATIENT CANNOT BE BILLED FOR THE DECLINED AMOUNT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR THE NETWORK PLAN COPAY, DEDUCTIBLE, OR COINSURANCE AMOUNTS. IF THE PATIENT IS BILLED FOR THE DECLINED AMOUNT, THE PATIENT SHOULD CALL THE CUSTOMER CARE PHONE NUMBER THAT IS LISTED ON THE BACK OF THEIR ID CARD.		
J9	DUE TO A RECENT SYSTEMS ISSUE RELATED TO YOUR BENEFITS, YOUR CLAIM WAS PROCESSED INCORRECTLY. IT HAS BEEN CORRECTED ON THIS EXPLANATION OF BENEFITS STATEMENT. WE APOLOGIZE FOR ANY INCONVENIENCE THIS MAY HAVE CAUSED YOU.		
KA	WE HAVE REQUESTED ADDITIONAL INFORMATION TO PROPERLY PROCESS YOUR CLAIM.	OA	16
KB	OUR RECORDS INDICATE THAT THIS INDIVIDUAL IS NOT ELIGIBLE FOR COVERAGE THIS CLAIM IS BEING DENIED. PLEASE CONTACT YOUR EMPLOYER FOR ELIGIBILITY VERIFICATION FOR THIS INDIVIDUAL. IF WE RECEIVE CORRECTED ELIGIBILITY INFORMATION, WE WILL REPROCESS THE CLAIM IN ACCORDANCE WITH YOUR BENEFIT PLAN.	PR	16
KC	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR PHYSICAL CONDITIONING PROGRAMS.	PR	96
KD	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR DEVICES USED SPECIFICALLY AS SAFETY ITEMS OR TO AFFECT PERFORMANCE PRIMARILY IN SPORTS-RELATED ACTIVITIES.	PR	96
KE	THIS CLAIM IS BEING FORWARDED FOR TRANSLATION. THE TOTAL CHARGE AND DATE OF SERVICE MAY NOT DISPLAY ACCURATE DATA UPDATED ONCE TRANSLATION IS COMPLETE.	CO	133
KF	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE HAVE RECEIVED.		
KG	THIS ANESTHESIA SERVICE WAS RECODED TO AN EQUIVALENT SERVICE. THE MOST APPROPRIATE PROCEDURE CODE MODIFIER WAS ASSIGNED BASED ON OTHER SERVICES PROCESSED FOR THIS PATIENT. THE MINUTES FOR THIS SERVICE WERE ADJUSTED AND WILL REFLECT TIME FOR ADD-ON PROCEDURE CODES, PHYSICAL STATUS MODIFIERS, AND/OR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. THE CHARGE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY/GLOBAL PROCEDURE AND WILL INCLUDE THE CHARGE FOR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE/ MODIFIER, ANESTHESIA MINUTES, AND CHARGE.	CO	B15
KH	THIS SERVICE LINE IS BEING RECODED TO REVISE THE ANESTHESIA MINUTES AND CHARGE.	CO	B15
KJ	THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES, PHYSICAL STATUS MODIFIERS, AND/OR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE AND WILL INCLUDE THE CHARGE FOR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED ANESTHESIA MINUTES AND CHARGE.	CO	B15
KK	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE MODIFIER, ANESTHESIA MINUTES, AND CHARGE.	CO	B15
KL	IN ACCORDANCE WITH YOUR EMPLOYERS' ENROLLMENT REQUIREMENTS, YOU MUST ENROLL YOUR NEWBORN CHILD(REN) WITHIN THE NUMBER OF DAYS SPECIFIED IN YOUR BENEFIT PLAN. FAILURE TO ENROLL YOUR BABY WILL AFFECT FUTURE CLAIM PROCESSING. PLEASE CONTACT YOUR EMPLOYER'S BENEFITS REPRESENTATIVE TO HAVE YOUR NEWBORN CHILD ADDED TO YOUR FILE AS AN ELIGIBLE DEPENDENT.	PR	32
KM	PLEASE SUBMIT RECORDS OF THE BENEFITS PAID BY YOUR BASIC GROUP INSURANCE POLICY SO WE CAN DETERMINE MAJOR MEDICAL BENEFITS.	OA	16
KN	WE HAVE RECONSIDERED THESE CHARGES BASED ON ADDITIONAL INFORMATION WE RECEIVED		
KO	YOUR PLAN COVERS HEALTH SERVICES PROVIDED BY A NETWORK PHYSICIAN AND A NETWORK HOSPITAL. THE ONLY EXCEPTION TO THIS EXCLUSION IS EMERGENCY SITUATIONS OR WHEN YOUR COMPANY AUTHORIZES HEALTH SERVICES THAT MEET BENEFIT CRITERIA AND ARE NOT AVAILABLE AT THE NETWORK HOSPITAL.	PR	38
KP	ACCORDING TO YOUR PLAN, WE HAVE APPLIED AN OUT-OF-NETWORK DEDUCTIBLE BECAUSE YOU DID NOT USE A NETWORK FACILITY.	PR	1
KQ	FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE ADDITIONAL ANESTHESIA MINUTES AND THE AMOUNT CHARGED FOR THE QUALIFYING CIRCUMSTANCE(S) SUBMITTED.	CO	B15
KR	YOUR PROVIDER ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. WE HAVE COORDINATED BENEFITS WITH YOUR OTHER INSURANCE	CO	22

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	CARRIER UP TO THE AGREED AMOUNT. YOU DO NOT HAVE TO PAY MORE THAN THE AGREED AMOUNT.		
KS	YOUR PLAN DOES NOT COVER SERVICES OR ITEMS FOR WHICH YOU ARE NOT REQUIRED TO PAY, OR IN THE ABSENCE OF YOUR PLAN COVERAGE YOU WOULD NOT HAVE BEEN CHARGED.	PR	96
KT	THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT. THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL INCLUDE ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES, PHYSICAL STATUS MODIFIERS, AND/OR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE AND WILL INCLUDE THE CHARGE FOR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE MODIFIER, ANESTHESIA MINUTES, AND CHARGE.	CO	B15
KU	THE EXTRA CHARGE FOR CARE BEFORE OR AFTER YOUR SURGERY IS NOT COVERED. THE COVERED SURGICAL FEE INCLUDES AN ALLOWANCE FOR CARE BEFORE AND AFTER THE SURGERY. THIS APPLIES WHETHER THE EXTRA CHARGE IS COMBINED WITH THE SURGICAL FEE OR LISTED BY ITSELF.	CO	59
KV	THIS PROCEDURE CODE IS NOT ELIGIBLE FOR AN ASSISTANT SURGEON. THEREFORE BENEFITS ARE NOT PAYABLE.	OA	54
KW	WE PROCESSED THESE CHARGES USING A PROCEDURE CODE THAT MORE ACCURATELY DESCRIBES THE SERVICES PROVIDED.	CO	97
KX	WE RECEIVED ONE OR MORE PROCEDURE CODES FOR THE SERVICES PROVIDED. WE USED A SINGLE PROCEDURE CODE THAT MORE APPROPRIATELY REPRESENTS THESE SERVICES. YOUR PLAN BENEFITS WERE APPLIED USING THIS SINGLE PROCEDURE CODE.		
KZ	THE CLAIM YOU SUBMITTED WITH BILATERAL MODIFIER 50 WILL BE REPROCESSED ON TWO LINES RATHER THAN A SINGLE LINE.	CO	97
K0	FOR PROCESSING PURPOSES, WE ARE ADJUSTING THE CLAIM YOU SUBMITTED WITH BILATERAL MODIFIER 50 ON TWO LINES RATHER THAN ONE LINE.	CO	97
K1	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA SERVICE CODE FOR CLAIM PROCESSING PURPOSES. THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE AND CHARGE.	CO	B15
K2	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE, ANESTHESIA MINUTES, AND CHARGE.	CO	B15
K3	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA SERVICE CODE FOR CLAIM PROCESSING PURPOSES. THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES, PHYSICAL STATUS MODIFIERS, AND/OR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE AND WILL INCLUDE THE CHARGE FOR QUALIFYING CIRCUMSTANCES WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE, ANESTHESIA MINUTES, AND CHARGE.	CO	B15
K4	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE, PROCEDURE CODE MODIFIER, ANESTHESIA MINUTES, AND CHARGE.	CO	B15
K5	WE RECEIVED THE EXPLANATION OF BENEFITS STATEMENT FROM YOUR PRIMARY INSURANCE CARRIER. PLEASE SEND US THE ITEMIZED BILLS THAT CORRESPOND TO THIS STATEMENT.	OA	16
K6	AFTER REVIEWING YOUR FILES, WE FOUND THAT THIS PAYMENT WAS ORIGINALLY PROCESSED ON AN INCORRECT FAMILY MEMBER. SINCE THE ORIGINAL CALCULATION OF BENEFITS WAS CORRECT, NO ADDITIONAL BENEFITS ARE PAYABLE. THIS ADJUSTMENT WAS PERFORMED TO CORRECT YOUR FILES.	CR	129
K7	AFTER REVIEWING YOUR FILES, WE FOUND THAT THIS PAYMENT WAS ORIGINALLY PROCESSED ON AN INCORRECT FAMILY MEMBER. THE ORIGINAL CALCULATION OF BENEFITS WAS INCORRECT. THIS PAYMENT REPRESENTS THE ADDITIONAL BENEFITS DUE.	CR	129
K8	WE RECEIVED ADDITIONAL INFORMATION AND REPROCESSED YOUR CLAIM.		
K9	THIS IS A RECONSIDERATION OF CHARGES PREVIOUSLY PROCESSED. YOUR ENROLLMENT AND ELIGIBILITY QUESTIONS WERE RESOLVED.		
LA	YOUR PLAN ONLY COVERS UPPER AND LOWER JAWBONE SURGERY WHEN IT IS FOR THE DIRECT TREATMENT OF ACUTE TRAUMATIC INJURY OR FOR CANCER.	PR	96
LB	YOUR PLAN DOES NOT COVER ORTHOGNATIC SURGERY, JAW ALIGNMENT, OR TREATMENT FOR THE TEMPOROMANDIBULAR JOINT (TMJ).	PR	96
LC	ACCORDING TO OUR RECORDS, WE NEED A CURRENT TREATMENT PLAN FROM THE PATIENT'S PHYSICIAN. WHEN WE RECEIVE THIS, CHARGES WILL	OA	16

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LD	BE CONSIDERED. ACCORDING TO YOUR PLAN, ONLY THE FIRST VISIT FOR NORMAL NEWBORN CARE IS COVERED. ADDITIONAL VISITS FOR NEWBORN CARE ARE NOT COVERED.	PR	96
LE	ACCORDING TO YOUR PLAN, MEDICAL EQUIPMENT RENTALS, UP TO THE PURCHASE PRICE, ARE COVERED.	PR	96
LF	ACCORDING TO YOUR PLAN, ONLY ONE SERVICE PER DAY IS COVERED.	PR	95
LG	IN ORDER TO COMPLETE THE PROCESSING OF THIS CLAIM, PLEASE SEND A BILL WITH A COMPLETE LIST OF SERVICES PERFORMED, THE PHYSICIAN OR PROVIDER'S NAME, ADDRESS, TELEPHONE NUMBER, AND TAX ID NUMBER, TO THE ADDRESS INDICATED ABOVE.	CO	16
LH	BEFORE WE CAN CONSIDER YOUR CLAIM, PLEASE SEND US THE DATE AND PLACE OF THE ACCIDENT AND A BRIEF DESCRIPTION OF HOW THE ACCIDENT HAPPENED.	OA	16
LI	IS THE ABOVE DEPENDENT A FULL-TIME STUDENT? IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE COLLEGE OR INSTITUTION HE/SHE IS ATTENDING.	OA	16
LJ	WE NEED A DIAGNOSIS FOR THE ABOVE CHARGES BEFORE YOUR CLAIM CAN BE CONSIDERED. PLEASE HAVE YOUR DOCTOR WRITE THE DIAGNOSIS ON THIS STATEMENT AND RETURN IT TO US AT THE ABOVE ADDRESS FOR PROCESSING.	OA	D21
LK	WE NEED A HEALTH CLAIM FORM TO PROCESS YOUR CLAIM. PLEASE SUBMIT A COMPLETED HEALTH CLAIM FORM, ALONG WITH THIS EXPLANATION OF BENEFITS, TO US AT THE ABOVE ADDRESS.	OA	16
LL	THIS SURCHARGE, MADE IN ACCORDANCE WITH ACT 131 OF THE 1990 LOUISIANA REGULAR LEGISLATIVE SESSION, IS NOT PAYABLE FOR ONE OR MORE OF THE FOLLOWING REASONS: A. THIS IS NOT AN INSURED BENEFIT PLAN SECONDARY TO ANOTHER BENEFIT PLAN.	PR	96
LM	THIS SURCHARGE IS BEING PAID IN ACCORDANCE WITH ACT 131 OF THE 1990 LOUISIANA REGULAR LEGISLATIVE SESSION.	CO	96
LN	NO DOLLAR AMOUNT WAS BILLED. THEREFORE, NO PAYMENT HAS BEEN MADE.		
LO	ADDITIONAL CHARGES AND OR CORRECTED BILLING HAS BEEN CONSIDERED. THIS IS A CORRECTED EXPLANATION OF BENEFITS STATEMENT. THE ORIGINAL EXPLANATION OF BENEFITS YOU RECEIVED WAS INCORRECT DUE TO AN OVERPAYMENT.		
LP	THIS CLAIM CANNOT BE PROCESSED BECAUSE YOUR PROVIDER EITHER 1) DID NOT SUBMIT THE CLAIM WITHIN THE CONTRACTED TIME FRAME OR 2) SUBMITTED THE CLAIM BUT DID NOT SEND DETAILS ON WHY IT SHOULD BE REPROCESSED. IN SITUATION 1, YOU CANNOT BE BILLED FOR ANY AMOUNT OVER YOUR COPAY, COINSURANCE, OR DEDUCTIBLE. YOUR PROVIDER CAN ASK US TO RECONSIDER THE CLAIM BY DETAILING THE DATE THE CLAIM WAS ORIGINALLY FILED, ALONG WITH THIS EXPLANATION OF BENEFITS. IF THE SUBMISSION WAS ELECTRONIC, WE NEED A COPY OF THE ACCEPTANCE REPORT. IF SITUATION 2 OCCURRED, RESUBMIT WITH DETAILS OF WHY THE CLAIM SHOULD BE RECONSIDERED.	CO	29
LQ	THIS PERSON IS NOT ELIGIBLE FOR COVERAGE UNDER THIS PLAN.	OA	177
LR	ACCORDING TO YOUR PLAN, THIS CONDITION AND ALL RELATED CONDITIONS	PR	167
LS	YOUR PLAN COVERS REASONABLE CHARGES FOR COVERED HEALTH SERVICES. THE REASONABLE CHARGE IS BASED ON AMOUNTS CHARGED BY OTHER PHYSICIANS OR HEALTH CARE PROFESSIONALS IN THE AREA FOR SIMILAR SERVICES OR SUPPLIES. THE PHYSICIAN OR HEALTH CARE PROFESSIONAL MAY BILL YOU FOR THE AMOUNT DECLINED. IF THIS CLAIM IS FOR SURGERY, PLEASE CONTACT OUR CUSTOMER CARE CENTER AT THE PHONE NUMBER LISTED ON YOUR ID CARD.	CO	45
LU	ACCORDING TO OUR RECORDS, WE DID NOT RECEIVE NOTIFICATION FOR THIS SERVICE, AS REQUIRED BY YOUR PLAN. THEREFORE, NO BENEFITS ARE AVAILABLE.	PR	62
LV	CHARGES CANNOT BE CONSIDERED BECAUSE SERVICES BILLED WERE NOT PERFORMED.	CO	96
LW	WE CANNOT PAY THIS CLAIM BECAUSE WE ARE UNABLE TO VERIFY THIS FACILITY HAS AN ACTIVE AMBULATORY SURGERY LICENSE. PROOF OF LICENSURE IS REQUIRED IN ORDER TO BILL ON A UB-92.	CO	17
LY	THIS PORTION OF THE CLAIM IS INFORMATIONAL ONLY. THERE IS NO PATIENT RESPONSIBILITY.		
L1	ACCORDING TO YOUR HEALTH PLAN, THESE DENTAL EXPENSES ARE NOT COVERED. PLEASE SUBMIT THESE EXPENSES TO YOUR DENTAL PLAN.	PR	96
L3	ACCORDING TO OUR RECORDS, THE \$1,250 LIFETIME MAXIMUM BENEFIT FOR JAW JOINT DISORDERS HAS BEEN REACHED WITH THIS PAYMENT. NO ADDITIONAL BENEFITS ARE AVAILABLE FOR THIS CONDITION.	PR	35
L4	ACCORDING TO YOUR PLAN, MAXIMUM BENEFITS FOR JAW JOINT DISORDER HAVE BEEN MET.	PR	35

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L5	THE ALLOWED AMOUNT FOR THIS CLAIM WAS PREVIOUSLY ALLOWED AND NO ADDITIONAL PAYMENT IS DUE.	PR	18
L6	ACCORDING TO YOUR PLAN, MATERNITY BENEFITS FOR DEPENDENT CHILDREN ARE NOT AVAILABLE.	PR	167
L7	ACCORDING TO YOUR PLAN, CHARGES ARE NOT COVERED IF YOU ARE INJURED PERFORMING A JOB FOR WHICH YOU ARE BEING PAID OR FOR AN ILLNESS THAT IS COVERED BY WORKER'S COMPENSATION LAW.	PR	19
L9	BENEFITS HAVE BEEN REDUCED AS A RESULT OF COORDINATION OF BENEFITS WITH THE AUTO INSURANCE CARRIER.	PR	21
MA	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR IN VITRO FERTILIZATION.	PR	96
MB	YOU HAVE REACHED THE LIFETIME MAXIMUM BENEFIT ALLOWED BY YOUR PLAN.	PR	35
MC	ACCORDING OUR RECORDS, THIS EXPENSE WAS APPLIED TO AN INCORRECT SOCIAL SECURITY NUMBER. YOUR FILE HAS BEEN CORRECTED.	CR	129
MD	THIS IS AN ADJUSTMENT TO YOUR CLAIM. ACCORDING TO OUR RECORDS, THESE CHARGES WERE PROCESSED UNDER AN INCORRECT SOCIAL SECURITY NUMBER. YOUR FILE HAS BEEN CORRECTED.	CR	129
ME	YOUR PLAN DOES NOT COVER SERVICES OR ASSOCIATED EXPENSES FOR THIS ITEM BECAUSE IT DOES NOT MEET THE BENEFIT PLAN DEFINITION FOR BEING CONSIDERED DURABLE MEDICAL EQUIPMENT.	PR	96
MF	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR GAMETE OR ZYGOTE INTRAFALLOPIAN TRANSFER (GIFT/ZIFT) PROCEDURES, OR ANY RELATED PRESCRIPTION MEDICATION TREATMENT.	PR	96
MG	THE SUBMITTED PROCEDURE CODE MODIFIER FOR SUPERVISION OF MORE THAN FOUR CONCURRENT ANESTHESIA SERVICES IS NOT A REIMBURSABLE SERVICE. THEREFORE, BENEFITS ARE NOT PAYABLE.	PR	96
MH	WE RECEIVED AND FORWARDED THE MEDICAL RECORDS THAT CARE PROGRAMS REQUESTED. CARE PROGRAMS WILL REVIEW THIS INFORMATION AND MAKE A DETERMINATION SOON. WE WILL NOTIFY YOU OF THE OUTCOME. THANK YOU FOR YOUR PATIENCE.		
MI	YOUR PLAN DOES NOT COVER THIS BLOOD DONATION, STORAGE, AND/OR ASSOCIATED EXPENSE.	PR	96
MJ	THE DOCUMENTATION WE RECEIVED DOES NOT SUPPORT THE CODES THAT WERE BILLED. BENEFITS ARE LIMITED TO DOCUMENTED SERVICES, THEREFORE, BENEFITS ARE NOT AVAILABLE.	PR	50
MK	IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, PLEASE CONTACT YOUR PLANT NURSE AT JOHNSON CONTROLS, INC.		
ML	THE MODIFIER SUBMITTED OR THE MODIFYING CIRCUMSTANCES HAVE BEEN CONSIDERED IN DETERMINING THE COVERED AMOUNT.	CO	
MM	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF SPECIFIC BENEFIT PLAN LANGUAGE.		
MN	MEDICARE INITIALLY DENIED THIS CHARGE BECAUSE IT IS SHOWING AN INVALID MEDICARE CODE. BEFORE WE CAN CONSIDER THIS CHARGE, YOUR HEALTH CARE PROVIDER NEEDS TO CHANGE THE INCORRECT PROCEDURE CODE TO A VALID MEDICARE PROCEDURE CODE AND RESUBMIT THIS BILL TO MEDICARE SO THEY CAN RECONSIDER THIS CHARGE. AFTER MEDICARE COMPLETES THEIR REVIEW, PLEASE RESUBMIT THE DOCUMENTATION TO US SO WE CAN CONTINUE TO PROCESS THIS CLAIM.	OA	16
MP			
MR	PLEASE CONTACT AURORA EMPLOYEE ASSISTANCE PROGRAM (EAP) BEHAVIORAL HEALTH MANAGEMENT AT 1-800-236-3231 IN ORDER TO RECEIVE THE HIGHEST LEVEL OF BENEFITS AVAILABLE UNDER THE PLAN.	PR	62
MS	ACCORDING TO OUR RECORDS, THE TREATMENT PROGRAM RECOMMENDED BY PSYCHSYSTEMS REVIEW WAS NOT FOLLOWED. THEREFORE, CHARGES FOR THIS PROVIDER WERE COVERED AT 60% AFTER AN ADDITIONAL \$200.00 DEDUCTIBLE	CO	62
MU	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR EMBRYO TRANSPLANT, DONOR OVUM AND SEMEN, AND RELATED COSTS, INCLUDING COLLECTION AND PREPARATION.	PR	96
MW	THIS PROCEDURE OR SUPPLY IS PART OF THE GLOBAL SERVICE AND HAS BEEN COMBINED WITH THAT SERVICE.	CO	97
MX	THIS IS THE COMBINED CHARGE FOR ALL SERVICES BILLED FOR THE GLOBAL PROCEDURE.		
MY	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR PREVENTIVE SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
MZ	YOUR PLAN HAS A MAXIMUM COVERED AMOUNT PER VISIT FOR THIS SERVICE OR TREATMENT.	PR	35

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M0	THIS DATE EXCEEDS THE NUMBER OF VISITS INDICATED IN THE ACN GROUP NOTIFICATION RESPONSE NOT BE BILLED FOR AMOUNTS DECLINED WHEN ADMINISTRATIVE REQUIREMENTS ARE NOT FOLLOWED.	CO	62
M4	ACCORDING TO OUR RECORDS, THIS EXPENSE WAS APPLIED TO YOUR DEDUCTIBLE BY MISTAKE. YOUR FILE HAS BEEN CORRECTED.	CR	1
M5	ACCORDING TO OUR RECORDS, THIS EXPENSE WAS APPLIED TO ANOTHER FAMILY MEMBER. YOUR FILE HAS BEEN CORRECTED.	CR	129
M6	THIS IS A RECONSIDERATION OR A PREVIOUSLY PROCESSED CLAIM.		
M7	THIS ADJUSTMENT CORRECTS YOUR CALENDAR YEAR DEDUCTIBLE. HOWEVER, NO ADDITIONAL BENEFITS ARE DUE.	PR	1
M8	ADDITIONAL PAYMENT IS BEING MADE AS A RESULT OF ADJUSTING YOUR DEDUCTIBLE.	PR	1
M9	ON YOUR OTHER INSURANCE PLAN'S PAYMENT STATEMENT SUBMITTED. IT APPEARS THAT YOUR LIABILITY IS ZERO, THEREFORE, WE HAVE NOT ISSUED A BENEFIT. IF YOU DO NOT AGREE, PLEASE CONTACT US WITH FURTHER INFORMATION.	PR,23	3
NA	OUR RECORDS SHOW THERE HAS NOT BEEN EXPENSES SUBMITTED FOR MORE THAN THREE MONTHS FOR THIS CONDITION. THEREFORE, ACCORDING TO YOUR PLAN, A NEW DEDUCTIBLE MUST BE SATISFIED TO ESTABLISH A NEW BENEFIT PERIOD.	PR	1
NB	A BETTER BENEFIT COULD HAVE BEEN OBTAINED BY RECEIVING SERVICES FROM A PHYSICIAN OR HEALTH CARE PROVIDER IN THE EMPLOYER PLAN'S SPECIFIC NETWORK.	PR	38
NC	ACCORDING TO YOUR PLAN, SERVICES THAT RESULT FROM MENTAL OR NERVOUS DISORDERS, ALCOHOLISM OR CHEMICAL DEPENDENCY ARE EXCLUDED.	PR	96
ND	A NON NETWORK HEALTH CARE PROVIDER OR FACILITY PROVIDED THESE SERVICES. YOUR CLAIM HAS BEEN PAID BASED ON YOUR BENEFIT PLAN, WHICH USES BENCHMARKS ESTABLISHED BY THE FEDERAL GOVERNMENT, INCLUDING RATES AND METHODOLOGIES USED BY THE MEDICARE PROGRAM. YOU ARE RESPONSIBLE FOR PAYING THE AMOUNT IN THE NOT COVERED COLUMN. THE NOT COVERED AMOUNT DOES NOT APPLY TO YOUR OUT OF POCKET MAXIMUM.	PR	38
NE	A NON NETWORK HEALTH CARE PROVIDER OR FACILITY PROVIDED THESE SERVICES. YOUR CLAIM HAS BEEN PAID BASED ON YOUR BENEFIT PLAN, WHICH PROVIDES REIMBURSEMENT TO NON NETWORK HEALTH CARE PROVIDERS OR FACILITIES AT 50 PERCENT OF THEIR BILLED CHARGES. YOU ARE RESPONSIBLE FOR PAYING THE AMOUNT IN THE NOT COVERED COLUMN. THE NOT COVERED AMOUNT DOES NOT APPLY TO YOUR OUT OF POCKET MAXIMUM.	PR	38
NF PR	ACCORDING TO YOUR BENEFIT PLAN, THE BENEFIT ALREADY CONSIDERED FOR THIS CONFINEMENT WAS THE MAXIMUM AMOUNT PAYABLE FOR THIS STAY. YOU ARE RESPONSIBLE FOR PAYING THE AMOUNT IN THE NOT COVERED COLUMN. THE NOT COVERED AMOUNT DOES NOT APPLY TO YOUR OUT OF POCKET MAXIMUM. APPLY TO YOUR OUT OF POCKET MAXIMUM.	119	3
NG	YOUR BENEFITS ARE LOWER BECAUSE WE DID NOT RECEIVE NOTIFICATION FOR THIS SERVICE.	PR	62
NH	YOUR BENEFITS ARE LOWER BECAUSE WE DID NOT RECEIVE NOTIFICATION FOR THIS SERVICE AND YOU DID NOT USE A NETWORK PROVIDER.	PR	62
NI	ACCORDING TO YOUR PLAN, BENEFITS ARE ONLY AVAILABLE WHEN A NETWORK PHYSICIAN OR HEALTH CARE PROVIDER IS USED. SINCE A NETWORK PHYSICIAN OR HEALTH CARE PROVIDER WAS NOT USED, NO BENEFITS ARE AVAILABLE FOR THIS EXPENSE.	PR	38
NJ	YOUR BENEFITS ARE LOWER BECAUSE YOU DID NOT USE A NETWORK PHYSICIAN OR HEALTH CARE PROVIDER.	PR	38
NK	NON-CLEAN CLAIM/DATA ELEMENT DEFICIENCY.		
NL	ACCORDING TO YOUR PLAN, YOU ARE REQUIRED TO NOTIFY YOUR PRIMARY PHYSICIAN BEFORE YOU SEE ANOTHER HEALTH CARE PROVIDER. YOUR BENEFITS WERE REDUCED BECAUSE YOU DID NOT NOTIFY YOUR PRIMARY PHYSICIAN AND YOU DID NOT USE A NETWORK HEALTH CARE PROVIDER.	PR	62
NM	ACCORDING TO YOUR PLAN, YOU MUST NOTIFY YOUR PRIMARY PHYSICIAN BEFORE YOU SEE ANOTHER HEALTH CARE PROVIDER. YOU DID NOT CALL YOUR PRIMARY PHYSICIAN SO YOUR BENEFITS HAVE BEEN REDUCED.	PR	62
NN	THROUGH A PRE-PAID AGREEMENT, THESE SERVICES ARE COVERED UNDER MONTHLY PAYMENT. THE MEMBER IS NOT RESPONSIBLE TO PAY THESE EXPENSES. HOWEVER, IF APPLICABLE TO THE PLAN, THE MEMBER IS RESPONSIBLE FOR THE COPAY AMOUNT.	PR	24
NO	UNDER YOUR BENEFIT PLAN, OUT-OF-NETWORK PROVIDER SERVICES ARE PAYABLE AT THE NETWORK LEVEL IF YOU CONTACT YOUR PRIMARY	CO	42

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	PHYSICIAN AND WE RECEIVE NOTIFICATION IN ADVANCE. SINCE YOU CONTACTED YOUR PRIMARY PHYSICIAN AND NOTIFIED US IN ADVANCE, THESE SERVICES HAVE BEEN PAID AT THE NETWORK LEVEL.		
NP	ACCORDING TO YOUR PLAN, FAILURE TO CONTACT YOUR PRIMARY PHYSICIAN BEFORE INCURRING THESE EXPENSES RESULTS IN A LOWER BENEFIT PAYMENT. SINCE YOUR PRIMARY PHYSICIAN WAS NOT CONTACTED IN ADVANCE, BENEFITS ON THESE EXPENSES HAVE BEEN PAID AT THE LOWER LEVEL.	PR	62
NQ	ACCORDING TO YOUR PLAN, AUTHORIZATION IS REQUIRED PRIOR TO OBTAINING THIS NON-NETWORK SERVICE. OUR RECORDS INDICATE THAT NO AUTHORIZATION WAS OBTAINED AND AS RESULT, NO BENEFIT IS AVAILABLE. THE PATIENT IS RESPONSIBLE FOR ALL CHARGES.	CO	62
NR	YOUR PLAN REQUIRES YOU TO NOTIFY US OF THESE SERVICES IF MORE THAN TEN VISITS ARE REQUIRED. IF IT APPEARS THAT MORE THAN TEN VISITS WILL BE REQUIRED, PLEASE CALL VALUEOPTIONS BY THE SEVENTH SESSION.	PR	62
NS	THIS DURABLE MEDICAL EQUIPMENT (DME) / PROSTHETICS AND ORTHOTICS (P&O) SERVICE WAS SUBMITTED TO UNITEDHEALTHCARE IN ERROR. ANOTHER CLAIMS ADMINISTRATOR IS RESPONSIBLE FOR CONSIDERING THIS CHARGE. PLEASE SUBMIT THIS CLAIM TO THE SUPPORT PROGRAM, P.O. BOX 82060, ROCHESTER, MI 48308. CHARGES FOR DME / P&O SERVICES RECEIVED PRIOR TO JUNE 1, 2005, SHOULD CONTINUE TO BE SUBMITTED TO UNITEDHEALTHCARE. IF YOU HAVE QUESTIONS, PLEASE CALL THE SUPPORT PROGRAM AT 1 (800) 831-0999.	CO	109
NT	ACCORDING TO YOUR PLAN, THE SERVICES OR PROCEDURES PERFORMED HAVE BEEN PAID AT THE NETWORK LEVEL OF BENEFITS.	OA	
NU	MEDCLAIM SERVICES IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
NW	ACCORDING TO YOUR PLAN, THIS HEARING SERVICE IS NOT COVERED.	PR	96
NX	OUR RECORDS INDICATE THAT THE PATIENT HAS PAID THESE CHARGES IN FULL FOR SERVICES RENDERED BY A CONTRACTED PROVIDER. THE PROVIDER'S CONTRACTED RATE MAY BE LESS THAN THE BILLED AMOUNT. THEREFORE, A REFUND FROM THE HEALTH CARE PROVIDER MAY BE DUE THE PATIENT.	CO	B13
NZ	A NON-NETWORK HEALTH CARE PROVIDER OR FACILITY FURNISHED THESE SERVICES. YOUR CLAIM HAS BEEN PAID BASED ON YOUR BENEFIT PLAN, AS SPECIFIED IN YOUR COVERAGE DOCUMENT, WHICH USES BENCHMARKS ESTABLISHED BY THE FEDERAL GOVERNMENT, INCLUDING RATES AND METHODS USED BY	PR	38
	SERVICES YOU RECEIVED, YOUR CLAIM WAS PAID AT 50% OF THE ALLOWED AMOUNT OF YOUR PROVIDER'S BILLED CHARGES. YOU ARE RESPONSIBLE FOR PAYING		
	TO YOUR OUT OF POCKET MAXIMUM.		
N1	ACCORDING TO OUR RECORDS, YOU HAVE REACHED THE MAXIMUM BASIC BENEFIT AMOUNT ALLOWED BY YOUR PLAN.	PR	35
N2	THIS AMOUNT EXCEEDS THE MAXIMUM BENEFIT ALLOWED BY YOUR PLAN.	PR	35
N3	ACCORDING TO YOUR PLAN, HEARING EVALUATIONS FOR A CONDITION NOT REQUIRING THE PRESCRIPTION OF A HEARING AID IS NOT COVERED.	PR	96
N4	ACCORDING TO YOUR PLAN, HEARING SERVICES PROVIDED BY A NON-PARTICIPATING PHYSICIAN OR HEALTH CARE PROVIDER ARE NOT COVERED.	PR	38
N5	ACCORDING TO YOUR PLAN, BINAURAL HEARING AIDS ARE NOT COVERED UNLESS PRESCRIBED FOR CHILDREN UNDER 19 YEARS OF AGE WHEN SUCH AIDS WILL COMPENSATE FOR HEARING LOSS IN BOTH EARS AND CORRECT OR PREVENT SPEECH IMPAIRMENT.	PR	96
N6	ACCORDING TO YOUR PLAN, HEARING AID SERVICES OBTAINED AFTER SIX MONTHS FROM THE DATE OF THE MEDICAL EXAMINATION OF THE EAR BY THE PHYSICIAN ARE NOT COVERED.	PR	96
N7	ACCORDING TO YOUR PLAN, BENEFITS ARE ONLY AVAILABLE AT THE NETWORK LEVEL WHEN A NETWORK PHYSICIAN OR HEALTH CARE PROVIDER IS USED. SINCE YOU USED AN OUT OF AREA PROVIDER, YOUR BENEFITS ARE BASED ON THE OUT OF NETWORK LEVEL. THE UNITEDHEALTHCARE CONTRACTUAL FEE HAS BEEN APPLIED. YOU ARE RESPONSIBLE FOR ANY DEDUCTIBLE OR COINSURANCE.	PR	38
N8	ABP ADMINISTRATORS IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2

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N9	ACCORDING TO OUR RECORDS, YOU HAVE REACHED THE WELL BABY CARE BENEFIT MAXIMUM ALLOWED BY YOUR PLAN.	PR	35
OB	THIS AMOUNT REPRESENTS CARRYOVER DEDUCTIBLE/OUT-OF-POCKET(OOP). CARRYOVER DEDUCTIBLE/OOP IS ANY AMOUNT APPLIED TO YOUR CURRENT DEDUCTIBLE/OOP BALANCES FROM THE LAST QUARTER OF THE PREVIOUS PLAN YEAR. FOR EXAMPLE, OCT-DEC CLAIMS APPLIED FOR A CALENDAR YEAR PLAN, PLAN.		
OC	YOUR PLAN LIMITS BENEFITS FOR EMERGENCY CARE. THE INFORMATION WE HAVE DOES NOT SUPPORT THE DEFINITION OF EMERGENCY SERVICES.THE NOT COVERED AMOUNT IS THE PATIENT'S RESPONSIBILITY. IF YOU HAVE ADDITIONAL INFORMATION WHICH YOU BELIEVE SUPPORTS THAT THESE SERVICES DO MEET THE PLAN REQUIREMENTS FOR EMERGENCY CARE, PLEASE SEND IT TO US FOR OUR CONSIDERATION.	PR	40
OD	ACCORDING TO OUR INFORMATION, THESE SERVICES ARE RELATED TO AN ON-DUTY INJURY. ON-DUTY INJURY CLAIMS MUST BE SENT DIRECTLY TO CONTINUUM HEALTHCARE, ATTN: ABR DEPARTMENT, 15 RIVER ROAD, SUITE 100, WILTON, CT 06897. THIS CLAIM HAS BEEN SENT TO THEM. YOU CAN CALL THEM AT 1-800-219-8184 WITH ANY QUESTIONS.	PR	19
OE	WE USED A NETWORK PROVIDER DISCOUNT BECAUSE YOU USED A NETWORK PROVIDER FOR THESE SERVICES. BUT, SINCE WE DID NOT RECEIVE NOTIFICATION FOR THESE SERVICES, YOUR BENEFITS HAVE BEEN LOWERED.	CO	62
OG	THIS ANESTHESIA SERVICE IS BEING RECODED TO AN EQUIVALENT ANESTHESIA CODE FOR CLAIM PROCESSING PURPOSES.	CO	B15
OH	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA CODE FOR CLAIM PROCESSING PURPOSES.	CO	B15
OJ	THIS SERVICE REPRESENTS AN ADD ON CODE AND MUST BE REPORTED WITH A PRIMARY PROCEDURE.	CO	B15
OL	YOU QUALIFY FOR A HIGHER BENEFIT LEVEL BECAUSE YOU CONTACTED US AND FOLLOWED THE RECOMMENDED TREATMENT PLAN. YOUR PROVIDER IS NOT A NETWORK PROVIDER SO THE COVERED AMOUNT IS LIMITED TO REASONABLE CHARGES.	PR	38
ON	YOUR PLAN DOES NOT COVER SERVICES AND SUPPLIES FOR SPINAL SUBLUXATIONS, MANIPULATIONS, OR MUSCLE STIMULATION (EXCEPT TREATMENT OF FRACTURES AND DISLOCATION OF THE EXTREMITIES).	PR	96
OP	THIS CLAIM HAS BEEN SUBMITTED TO THE INCORRECT BENEFIT ADMINISTRATOR. THIS AND ANY FUTURE CLAIMS FOR MENTAL HEALTH AND SUBSTANCE ABUSE SHOULD BE MAILED DIRECTLY TO: VALUEOPTIONS UNIT	CO	B11
OQ	THE SAME QUALIFYING CIRCUMSTANCES PROCEDURE CODE(S) WAS SUBMITTED MORE THAN ONCE FOR THIS ANESTHESIA SERVICE. ONLY ONE QUALIFYING CIRCUMSTANCES PROCEDURE CODE IS BEING CONSIDERED IN THE BENEFIT CALCULATION. THE AMOUNT CHARGED FOR THE OTHER SAME QUALIFYING CIRCUMSTANCES PROCEDURE CODE(S) IS BEING DENIED AS A DUPLICATE.	OA	B15
OR	ACCORDING TO YOUR PLAN, THIS HEALTH CARE PROVIDER DOES NOT MEET THE ELIGIBILITY STANDARDS FOR REIMBURSEMENT.	OA	52
OT	ACCORDING TO OUR RECORDS, THE DIAGNOSIS SUBMITTED IS NOT RELATED TO THIS PROCEDURE.	PR	11
OU	ACCORDING TO OUR RECORDS, A CURRENT OUTPATIENT TREATMENT REPORT IS NEEDED SO WE CAN CONSIDER THE CHARGES SUBMITTED.	PR	17
O3	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA SERVICE CODE FOR CLAIM PROCESSING PURPOSES. THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT. THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE/MODIFIER AND CHARGE.	CO	B15
O4	THE INITIAL OFFICE VISIT CODE WAS CHANGED TO A SUBSEQUENT OFFICE VISIT CODE. OUR RECORDS SHOW THAT THIS PATIENT HAS BEEN SEEN BY THIS PHYSICIAN OR OTHER HEALTH CARE PROVIDER BEFORE.	CO	150
O5	THIS PROCEDURE OR SUPPLY IS PART OF THE GLOBAL SERVICE. THESE CHARGES ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT.	CO	B15
O6	OUR RECORDS SHOW THESE SERVICES HAVE BEEN PREVIOUSLY SUBMITTED BY ANOTHER PHYSICIAN OR OTHER HEALTH CARE PROVIDER.	CO	18
O7	OUR RECORDS SHOW WE HAVE ALREADY PROCESSED THIS CHARGE.	CO	18
O8	BASED ON THE INFORMATION PROVIDED, THIS SERVICE IS UNPROVEN AND IS NOT COVERED. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT	PR	56

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	SCIENTIFIC EVIDENCE, THAT MEETS THE STANDARDS DESCRIBED IN YOUR BENEFIT PLAN LANGUAGE, THAT DEMONSTRATES THE SAFETY AND EFFECTIVENESS OF THIS SERVICE FOR YOUR PARTICULAR CONDITION.		
O9	THE NUMBER OF UNITS REPORTED EXCEEDS THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE. THEREFORE, THE NUMBER OF UNITS THAT EXCEED THE TYPICAL FREQUENCY PER DAY IS NOT BEING CONSIDERED. IF THE PROVIDER HAS ADDITIONAL DOCUMENTATION, PLEASE SEND IT TO US FOR CONSIDERATION.	PR	57
PA	AMERICAN PPO IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
PB	THESE CHARGES WERE INCORRECTLY PAID BY MEDICARE AS PRIME CARRIER. WE HAVE REDUCED THIS PAYMENT BY THE AMOUNT PREVIOUSLY PAID BY MEDICARE AND ISSUED REPAYMENT DIRECTLY TO MEDICARE TO THE EXTENT OF THE PLAN'S LIABILITY. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE TOTAL ALLOWABLE AMOUNTS ON THIS STATEMENT AND THE AMOUNTS PAID BY THE PLAN AND MEDICARE AS INDICATED ON THEIR STATEMENT. MEDICARE COULD BE E-BILLED FOR ANY BALANCE ONCE THEY HAVE ADJUSTED THEIR RECORDS TO INDICATE THEY ARE THE SECONDARY PAYER.		
PC	YOUR PLAN PROVIDES BENEFITS FOR SERVICES THAT ARE DETERMINED TO BE COVERED HEALTH SERVICES FOR TREATING AN ILLNESS OR INJURY. THE INFORMATION RECEIVED DOES NOT SUPPORT MEASURABLE PROGRESS TOWARDS DEFINED TREATMENT GOALS FOR SERVICES TO CONTINUE, THEREFORE, ADDITIONAL BENEFITS ARE NOT AVAILABLE. IF THERE IS ADDITIONAL INFORMATION, PLEASE SEND IT TO US FOR CONSIDERATION.	CO	50
PD	YOUR BENEFIT PLAN PROVIDES BENEFITS FOR SERVICES THAT ARE DETERMINED TO BE COVERED HEALTH SERVICES. THE INFORMATION RECEIVED DOES NOT SUPPORT MEASURABLE PROGRESS TOWARD DEFINED TREATMENT GOALS FOR THESE SERVICES. THEREFORE, ADDITIONAL BENEFITS ARE NOT AVAILABLE.	CO	50
PE	BASED ON THE INFORMATION PROVIDED, THIS SERVICE IS UNPROVEN AND IS NOT COVERED. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT SCIENTIFIC EVIDENCE, THAT MEETS THE STANDARDS DESCRIBED IN YOUR BENEFIT PLAN LANGUAGE, THAT DEMONSTRATES THE SAFETY AND EFFECTIVENESS OF THIS SERVICE FOR YOUR PARTICULAR CONDITION.	PR	56
PG	THIS PROCEDURE OR SUPPLY IS PART OF THE GLOBAL SERVICE. THESE CHARGES ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT.	CO	B15
PH	A PORTION OF THE ALLOWABLE AMOUNT IS FROM A RELATED CONFINEMENT CLAIM PREVIOUSLY CONSIDERED FOR THIS PATIENT.	CO	42
PI	WE CANNOT CONSIDER THIS CLAIM UNTIL WE RECEIVE THE DOCUMENTATION ALREADY REQUESTED FROM THE PHYSICIAN OR OTHER HEALTH CARE PROVIDER. THEREFORE, BENEFITS ARE NOT AVAILABLE.	OA	17
PJ	WE RECEIVED THE INFORMATION REQUESTED FROM YOU. HOWEVER, WE ARE UNABLE TO CONSIDER THESE EXPENSES UNTIL WE RECEIVE THE INFORMATION WE REQUESTED FROM THE PROVIDER(S).	OA	17
PK	THANK YOU FOR CONTACTING US. WE HAVE USED THE HIGHER BENEFIT LEVEL.	CO	42
PL	WE PROCESSED THIS EXPENSE USING THE HIGHER BENEFIT LEVEL BECAUSE YOU CONTACTED US. THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED IS NOT YOUR RESPONSIBILITY. YOU ARE RESPONSIBLE FOR ANY COPAYMENT, COINSURANCE, OR DEDUCTIBLE AMOUNTS.	CO	131
PM	BECAUSE YOU HAVE NOT CONTACTED US FOR THE CALENDAR YEAR FOR TREATMENT FOR THIS CONDITION, THE CHARGES WILL BE PAID AT THE LOWER LEVEL OF BENEFITS.	PR	62
PN	WE PROCESSED THIS CLAIM BASED ON THE ADDITIONAL INFORMATION WE RECEIVED.		
PP	BECAUSE YOU HAVE CONTACTED US BUT DID NOT FOLLOW THE RECOMMENDED TREATMENT PLAN, THE CHARGES WILL BE PAID AT THE LOWER LEVEL OF BENEFITS.	PR	95
PQ	YOUR PLAN DOES NOT COVER THIS SEPARATE CHARGE FOR DISPENSING AN ITEM.	PR	91
PR	YOUR PLAN DOES NOT COVER SERVICES RECEIVED AS A RESULT OF WAR OR ANY ACT OF WAR, WHETHER DECLARED OR UNDECLARED, OR CAUSED DURING SERVICE IN THE ARMED FORCES OF ANY COUNTRY.	PR	157
PS	ACCORDING TO YOUR PLAN, THIS PROVIDER OF SERVICE IS NOT COVERED.	OA	170
PU	THESE CHARGES MAY BE COVERED BY VALUEOPTIONS. IF YOU HAVE QUESTIONS CONCERNING COVERAGE OR TREATMENT PLEASE CALL THE VALUEOPTIONS NUMBER	CO	B11

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	SHOWN ON YOUR ID CARD.		
PW	YOUR PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. HOWEVER, YOU ARE RESPONSIBLE FOR ANY APPLICABLE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	CO	42
PZ	THE BENEFIT FOR THESE SERVICES IS DETERMINED AFTER WE COMPARE THE AMOUNT PAID BY MEDICARE TO WHAT IS PAYABLE UNDER YOUR PLAN, AFTER WE APPLY YOUR PLAN'S DEDUCTIBLE AND COINSURANCE (OUT-OF-POCKET) AMOUNTS. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	CO	22
P0	YOUR BENEFIT PLAN REQUIRES CERTAIN SERVICES BE PRE-CERTIFIED. COVERED EXPENSES ARE LOWER BECAUSE THESE SERVICES WERE NOT PRE-CERTIFIED.	PR	62
P1	PLEASE PROVIDE A DESCRIPTION OF THE SERVICES NOT COVERED BY MEDICARE.	OA	16
P3	ACCORDING TO OUR RECORDS, YOU HAVE BEEN OUT OF THE HOSPITAL FOR LESS THAN 60 DAYS. YOU WILL NOT BE CHARGED ANOTHER MEDICARE DEDUCTIBLE.	CO	22
P4	WE RECEIVED ADDITIONAL INFORMATION AND REPROCESSED THE CLAIM.		
P5	THESE CHARGES WERE PAID BY MEDICARE AS PRIME CARRIER. THIS IS INCORRECT. WE HAVE ISSUED REPAYMENT TO MEDICARE TO THE EXTENT OF THE PLAN'S LIABILITY.	CO	22
P6	IT HAS BEEN DETERMINED THAT MEDICARE HAS PRIMARY PAYER RESPONSIBILITY FOR THESE SERVICES. PLEASE RESUBMIT THIS BILL TO MEDICARE SO THEY CAN RECONSIDER THIS CHARGE. AFTER MEDICARE COMPLETES THEIR REVIEW, PLEASE RESUBMIT THE CLAIM AND MEDICARE EXPLANATION OF BENEFITS TO US FOR PROCESSING.	CO	22
P7	YOUR MEDICARE PART A DEDUCTIBLE WAS SATISFIED BY A PREVIOUS CONFINEMENT. THEREFORE, MEDICARE WILL COVER THESE ELIGIBLE PART A EXPENSES IN FULL. THESE EXPENSES WILL NOT BE CONSIDERED UNDER THIS PLAN.	PR	96
P8	THE AMOUNT ALLOWED IS THE MEDICARE DEDUCTIBLE AND/OR COINSURANCE.	CO	1
P9	THE EXCLUDED AMOUNT REPRESENTS THE PENALTY FOR NOT NOTIFYING THE PRE-CERTIFICATION REVIEW PROGRAM.	PR	62
QA	YOUR HEALTH CARE PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. HOWEVER, YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	PR	42
QB	YOUR BENEFIT HAS BEEN REDUCED BY 10 PERCENT BECAUSE VALUEOPTIONS DID NOT RECEIVE NOTIFICATION FOR THE CARE YOU RECEIVED.	PR	62
QC	ACCORDING TO YOUR PLAN, A HIGHER BENEFIT HAS BEEN APPLIED TO THESE SERVICES THAT WERE RECEIVED DURING AN EMERGENT CONFINEMENT.		
QD	THIS SERVICE LINE HAS BEEN MODIFIED TO INCLUDE THE REMAINING ANESTHESIA MINUTES GREATER THAN 60 FROM THE ADD-ON CODE.	CO	42
QE	THIS SERVICE LINE CONTAINS AN ADD-ON CODE THAT HAS A MAXIMUM ALLOWABLE OF 60 MINUTES. ADDITIONAL ANESTHESIA MINUTES THAT EXCEED 60 HAVE BEEN ADDED TO THE PRIMARY PROCEDURE.	CO	42
QF	FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE THE ADDITIONAL ANESTHESIA MINUTES FOR A PHYSICAL STATUS MODIFIER.	CO	B15
QG	WE HAVE REPROCESSED THIS CLAIM USING ADDITIONAL INFORMATION RECEIVED ABOUT THE DISCOUNT.		
QH	THESE CHARGES WERE RECONSIDERED AND PAYMENT MADE BASED ON THE ADDITIONAL INFORMATION WE RECEIVED.		
QI	CHARGES CANNOT BE CONSIDERED BECAUSE DOCUMENTATION DOES NOT SUPPORT THE LEVEL OF SERVICE BILLED.	CO	16
QJ	THIS PHYSICIAN OR HEALTHCARE PROVIDER IS NOT A NETWORK PROVIDER. HOWEVER, THEY HAVE ACCEPTED A DISCOUNT ON THIS SERVICE IN ACCORDANCE WITH THEIR MULTIPLAN (INCLUSIVE OF UP & UP AND PRO AMERICA) AGREEMENT. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT(S) IN THE "TOTAL PATIENT COST" COLUMN OF THIS STATEMENT. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.	CO	A2
QK	YOUR PROVIDER HAS AGREED TO ACCEPT THE ALLOWED FEE WHICH IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR PAYING THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. YOU ARE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AND COINSURANCE AMOUNTS THAT APPLY.	CO	A2
QM	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BASED ON		

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	ADDITIONAL INFORMATION WE RECEIVED.		
QN	YOUR CLAIM MAY HAVE BEEN SEPARATED FOR PROCESSING PURPOSES. ANY ADDITIONAL CHARGES WILL BE PROCESSED AS SOON AS POSSIBLE.	OA	133
QO	YOUR PLAN DOES NOT COVER STATE/SALES TAX WHEN THE CORRESPONDING SERVICE/ EXPENSE IS NOT COVERED. THE PATIENT IS RESPONSIBLE FOR THIS AMOUNT.	PR	96
QP	WE ARE UNABLE TO VERIFY YOUR ELIGIBILITY FOR COVERAGE AND THEREFORE CANNOT PROCESS YOUR CLAIM. PLEASE CONTACT VERIZON'S GTE BENEFITS CENTER AT 1-877-275-8947.	PR	31
QQ	YOU ELECTED A MEDICARE + CHOICE NETWORK PLAN AS YOUR PRIMARY (FIRST) MEDICAL COVERAGE. SINCE THE MEDICARE + CHOICE NETWORK DID NOT RECEIVE NOTIFICATION FOR THE SERVICES SHOWN ON YOUR CLAIM, BENEFITS UNDER THIS SECONDARY GROUP PLAN HAVE BEEN DETERMINED AS IF MEDICARE COVERED THE SERVICES.	PR	62
QR	THIS PAYMENT HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE REASONABLE CHARGE FOR YOUR AREA. IF YOU ARE BILLED FOR THE NOT COVERED AMOUNT, PLEASE CALL CONCENTRA PREFERRED SYSTEMS DIRECTLY AT 1-800-754-4116.	PR	45
QS	THESE CHARGES WERE RECONSIDERED AND PAYMENT MADE BASED ON THE ADDITIONAL INFORMATION WE RECEIVED.		
QT	THIS IS A CORRECTED EXPLANATION OF BENEFITS STATEMENT. THE ORIGINAL EXPLANATION OF BENEFITS YOU RECEIVED WAS INCORRECT DUE TO AN OVERPAYMENT.		
QU	YOUR HEALTH CARE PROVIDER HAS ACCEPTED A FEE THAT IS LESS THAN THE AMOUNT CHARGED. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED.	CO	131
QV	WE HAVE RECEIVED MORE INFORMATION. THE CHARGES HAVE BEEN RECONSIDERED, HOWEVER, NO ADDITIONAL BENEFITS ARE PAYABLE.		
QW	ACCORDING TO YOUR HEALTH PLAN, THESE CHARGES ARE NOT COVERED. PLEASE SUBMIT THEM TO YOUR VISION PLAN.	PR	109
QX	ACCORDING TO OUR RECORDS, THIS PAYMENT WAS ORIGINALLY PROCESSED UNDER AN INCORRECT POLICY NUMBER. YOUR FILE HAS BEEN CORRECTED.	CR	129
QY	THE AGE OF THIS PATIENT DOES NOT SATISFY THE AGE REQUIREMENT FOR ROUTINE EXAM BENEFITS. NO BENEFITS ARE PAYABLE FOR THESE SERVICES.	PR	96
QZ	VISITS TO AMERICAN SPECIALTY HEALTH NETWORK (ASHN) HEALTH CARE PROVIDERS AND NON-CONTRACTED HEALTH CARE PROVIDERS MUST BE AUTHORIZED BY ASHN. ALL VISITS THAT ARE NOT AUTHORIZED BY ASHN WILL NOT BE COVERED. PLEASE SEND THIS CLAIM DIRECTLY TO AMERICAN SPECIALTY HEALTH NETWORK (ASHN), P.O. BOX 509002, SAN DIEGO, CA 92510. FOR MORE INFORMATION, ENROLLEES MAY CALL 1 (800) 678-9133 AND HEALTH CARE PROVIDERS MAY CALL 1 (800) 972-4226.	CO	109
Q0	PAYMENT FOR THIS EXPENSE HAS ALREADY BEEN CONSIDERED BECAUSE ROUTINE MINIMAL ASSESSMENTS ARE PART OF THE CHIROPRACTIC MANIPULATION TREATMENT PRE-SERVICE PROCEDURE. THE PATIENT MAY NOT BE BILED FOR AMOUNTS DECLINED WHEN ADMINISTRATIVE REQUIREMENTS ARE NOT FOLLOWED.	CO	97
Q4	THIS SERVICE LINE IS BEING RECODED TO ADJUST THE ANESTHESIA MINUTES.	CO	B15
Q5	THIS SERVICE CODE HAS BEEN RECODED TO ADJUST THE ANESTHESIA MINUTES.	CO	B15
Q6	TOTAL ANESTHESIA MINUTES FOR THIS SERVICE EXCEEDS 999 MINUTES. FOR PROCESSING PURPOSES, IT WAS NECESSARY TO SPLIT THE TOTAL MINUTES AND CHARGE FOR THIS SERVICE INTO TWO SERVICE LINES.		
Q7	WE PROCESSED THESE CHARGES USING A PROCEDURE CODE MODIFIER THAT MORE ACCURATELY DESCRIBES THE SERVICES PROVIDED.	CO	4
Q8	THIS PROCEDURE CODE AND MODIFIER ARE THE SAME AS OR EQUIVALENT TO ANOTHER PROCEDURE CODE AND MODIFIER PREVIOUSLY SUBMITTED BY ANOTHER HEALTH CARE PROVIDER. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS SERVICE.	CO	18
Q9	THIS PROCEDURE CODE AND MODIFIER ARE THE SAME AS OR EQUIVALENT TO ANOTHER PROCEDURE CODE AND MODIFIER SHOWN ON THIS SAME CLAIM SUBMISSION OR A PRIOR CLAIM SUBMISSION. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS SERVICE.	CO	18
RA	BASED ON INFORMATION PROVIDED, THE DURABLE MEDICAL EQUIPMENT OR DEVICE DOES NOT MEET COVERAGE REQUIREMENTS. THERE ARE OTHER ALTERNATIVES THAT ARE MORE COST EFFECTIVE AND PRODUCE SIMILAR OUTCOMES. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE.	CO	50
RB	THESE EXPENSES WERE PREVIOUSLY PROCESSED UNDER MAJOR MEDICAL AT THE NON-NOTIFICATION 65% COINSURANCE RATE. THIS IS A RECONSIDERATION OF THESE EXPENSES, AND THIS CHECK REPRESENTS THE ADDITIONAL BENEFITS PAYABLE.		
RC	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR HOSPICE	PR	35

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	SERVICES AND/OR ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.		
RD	YOUR PLAN DOES NOT COVER ALLERGY INJECTIONS.	PR	96
RE	YOUR PLAN DOES NOT COVER HOME HEALTH CARE OR ASSOCIATED EXPENSES.	PR	96
RF	YOUR PLAN DOES NOT COVER PRESCRIPTIONS.	PR	96
RJ	YOUR PLAN DOES NOT COVER HOSPICE SERVICES OR ASSOCIATED EXPENSES.	PR	96
RO	YOUR PLAN DOES NOT COVER NON-SURGICAL TREATMENTS PERFORMED IN AN OUTPATIENT FACILITY OR DOCTORS OFFICE.	PR	96
RG	THE CORRESPONDENCE ATTACHED TO YOUR CLAIM WAS FORWARDED TO THE APPROPRIATE AREA FOR HANDLING. YOU SHOULD HEAR FROM THEM SOON.		
RH	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR ACUPUNCTURE SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
RI	ON AUG. 1, 2002, UNITEDHEALTHCARE BECAME THE NEW ADMINISTRATOR OF CATERPILLAR MEDICAL CLAIMS. UNITEDHEALTHCARE AGREED, BEGINNING JAN. 1, 2003, TO PROCESS ANY UNPROCESSED CLAIM WITH A SERVICE DATE PRIOR TO AUG. 1, 2002, AT 100 PERCENT OF BILLED CHARGES FOR COVERED MEDICAL EXPENSES. IN ORDER TO PROCESS THIS CLAIM, WE HAD TO CHANGE THE SERVICE DATE TO AUG. 4, 2002, SO OUR CLAIM SYSTEM COULD GENERATE AN EXPLANATION OF BENEFITS. PLEASE REFER TO THE LETTER YOU RECENTLY RECEIVED OUTLINING THE ACTUAL DATES OF SERVICE.		
RK	YOUR PLAN DOES NOT COVER THIS ENTERAL FEEDING OR ASSOCIATED EXPENSE.	PR	96
RL	WITH THIS PAYMENT, THE SKILLED NURSING FACILITY BENEFIT MAXIMUM OF 31 DAYS FOR THIS PERIOD OF CONFINEMENT HAS BEEN REACHED.	PR	119
RM	ACCORDING TO OUR RECORDS, THE SKILLED NURSING FACILITY BENEFIT MAXIMUM OF 31 DAYS FOR THIS PERIOD OF CONFINEMENT HAS BEEN MET.	PR	119
RN	ACCORDING TO OUR RECORDS, YOU HAVE ELECTED TO OPT OUT OF THE MEDICAL PLAN. THE ONLY COVERAGE YOU HAVE AS AN EMPLOYEE IS FOR WORK RELATED INJURIES. SINCE THIS CLAIM DOESN'T INDICATE THAT IT IS FOR A WORK RELATED INJURY, IT IS BEING DENIED.	PR	96
RP	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR HOME HEALTH CARE SERVICES AND/OR ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	35
RQ	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR THE TREATMENT OF HYPERIDROSIS (EXCESSIVE SWEATING).	PR	96
RR	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR THE TREATMENT OF SNORING.	PR	96
RS	CLAIMS MUST BE SUBMITTED WITHIN A TIMELY FILING LIMIT AS DETERMINED BY STATE LAW. AFTER REVIEWING YOUR APPEAL, THE INFORMATION SUBMITTED DOES NOT MEET THE REQUIREMENTS TO OVERTURN THE INITIAL CLAIM DETERMINATION. THEREFORE, NO BENEFITS ARE AVAILABLE.	OA	138
RT	THE REDUCTION IN GA-46000 BENEFITS CAUSED BY NON-NOTIFICATION, IS NOT COVERED UNDER GA-23111, PLAN E. AS A RESULT, GA-23111, PLAN E BENEFITS WERE CALCULATED BASED ON THE PAYMENT THAT WOULD HAVE BEEN MADE UNDER GA-46000, IF CARE COORDINATION HAD BEEN NOTIFIED.	PR	62
RU	THE CHARGES SHOWN ABOVE HAVE BEEN PROCESSED UNDER GA-46000. IF YOU ALSO HAVE COVERAGE UNDER GA-23111 PLAN E, THESE CHARGES WILL BE PROCESSED UNDER PLAN E, AND AN EXPLANATION OF BENEFITS MAILED TO YOU WITHIN A WEEK.	CO	22
RV	THE RADIOLOGY, PATHOLOGY OR ANESTHESIA CLAIM FOR THIS NON-NETWORK PHYSICIAN OR HEALTH CARE PROVIDER HAS BEEN PAID AT THE OUT OF NETWORK BENEFIT LEVEL BECAUSE OUR RECORDS DO NOT SHOW THAT YOU WERE REFERRED TO THIS HEALTH CARE PROVIDER BY A NETWORK HEALTH CARE PROVIDER. IF YOU WERE REFERRED TO THIS HEALTH CARE PROVIDER BY A NETWORK HEALTH CARE PROVIDER, PLEASE CONTACT OUR CUSTOMER CARE CENTER TO REQUEST A REVIEW OF THIS DECISION.	PR	38
RW	THE 'NOT COVERED' AMOUNT IS THE AMOUNT PAID BY MEDICARE.	CO	23
RX	ACCORDING TO OUR RECORDS, YOU DID NOT COMPLY WITH THE REQUIREMENTS OF YOUR CARE COORDINATION REVIEW PROGRAM FOR THIS CLAIM. USUALLY A PENALTY WOULD BE APPLIED RESULTING IN A DECREASED BENEFIT PAYMENT. HOWEVER, THE PENALTY HAS BEEN DEFERRED FOR THIS CLAIM TO ALLOW YOU TIME TO BECOME FAMILIAR WITH THE REQUIREMENTS OF THE PROGRAM.		
RY	YOUR PLAN DOES NOT COVER FACILITY OR PROFESSIONAL INPATIENT SERVICES.	PR	96
RZ	OUR RECORDS INDICATE YOUR COVERAGE IS PROVIDED BY AETNA HEALTH PLANS. THIS AND ANY FUTURE CLAIMS SHOULD BE SUBMITTED DIRECTLY TO:	OA	27

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	AETNA HEALTH PLANS P.O. BOX 7012 F250 DOVER, DELAWARE 19903-1512 TELEPHONE # 1-800-842-4044		
R0	ACCORDING TO OUR RECORDS, SINCE A NETWORK HEALTH CARE PROVIDER WAS USED, BENEFITS HAVE BEEN CALCULATED BASED UPON A NEGOTIATED RATE.	CO	45
R1	YOUR PLAN DOES NOT COVER NON-SURGICAL TREATMENTS PERFORMED IN AN OUTPATIENT FACILITY.	PR	96
R2	PLEASE SUBMIT A NEW BILL THAT INCLUDES THE TOTAL ANESTHESIA TIME SUBMITTED IN MINUTES AS WELL AS ANY ANESTHESIA MODIFIERS FOR EACH ANESTHESIA SERVICE SUBMITTED.		
R3	YOUR PLAN DOES NOT COVER MENTAL HEALTH SERVICES FOR THE TREATMENT OF MENTAL ILLNESS THAT WILL NOT SUBSTANTIALLY IMPROVE BEYOND THE CURRENT LEVEL OF FUNCTIONING.	PR	96
R4	YOUR PLAN DOES NOT COVER MENTAL HEALTH SERVICES FOR CONDITIONS NOT SUBJECT TO FAVORABLE MODIFICATION OR MANAGEMENT ACCORDING TO PSYCHIATRIC CARE GUIDELINES THAT HAVE BEEN DETERMINED BY THE MENTAL HEALTH/SUBSTANCE ABUSE DESIGNEE.	OA	96
R5	THIS WILL ACKNOWLEDGE THAT THE ABOVE BILLING RECEIVED IN OUR OFFICE HAS BEEN RETURNED TO YOUR WORK LOCATION FOR PROPER SUBMISSION.	CO	16
R6	SINCE WE CANNOT VERIFY COVERAGE ON THIS DEPENDENT THROUGH OUR CERTIFICATION PROCESS, WE ARE UNABLE TO PROVIDE BENEFITS. IF YOU HAVE QUESTIONS, PLEASE CONTACT YOUR BENEFITS DEPARTMENT.	OA	32
R7	ACCORDING TO OUR RECORDS, THIS DEPENDENT HAS NOT BEEN ENROLLED FOR COVERAGE. THEREFORE, WE ARE UNABLE TO PROVIDE BENEFITS.	OA	32
R8	YOUR PLAN DOES NOT COVER CONDUCT AND IMPULSE CONTROL DISORDERS, PERSONALITY DISORDERS, AND PARAPHILIAS.	PR	96
R9	WE HAVE RECONSIDERED THESE LAB AND/OR DIAGNOSTIC CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE HAVE RECEIVED.		
SA	REMEMBER, YOUR TOLL FREE AUTOMATED MEDICAL CLAIM INFORMATION SERVICE IS AVAILABLE FROM 7:00 AM TO 11:00 PM EASTERN STANDARD TIME (4:00 AM TO 8:00 PM PACIFIC TIME). CUSTOMER CARE PROFESSIONALS ARE AVAILABLE TO ASSIST YOU WITH CLAIM QUESTIONS DURING NORMAL BUSINESS HOURS.		
SB	YOUR PLAN DOES NOT COVER NUTRITIONAL AND ELECTROLYTE SUPPLEMENTS.	PR	96
SC	YOUR PLAN DOES NOT COVER SERVICES PROVIDED BY THIS PHYSICIAN OR HEALTH CARE PROVIDER.	PR	170
SE	THE ABOVE BENEFIT PAYMENT REFLECTS AN ADJUSTMENT TO THE EXCESS EXPENSE LIMITATION FOLLOWING SECONDARY CONSIDERATION.	CO	22
SF	IF YOU HAVE COVERAGE WITH ANOTHER INSURANCE COMPANY, PLEASE SEND US THEIR EXPLANATION OF BENEFITS AT THE ADDRESS SHOWN ABOVE. IF YOU DO NOT HAVE OTHER COVERAGE, PLEASE LET US KNOW IN WRITING AT THE ADDRESS SHOWN ABOVE.	OA	16
SG	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR THE REPAIR, REPLACEMENT, OR MAINTENANCE OF THIS IMPLANT.	PR	96
SH	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR THIS TYPE OF IMPLANT.	PR	96
SI	YOUR CLAIM FOR PRESCRIPTION DRUGS WAS SENT TO UNITEDHEALTHCARE IN ERROR. PLEASE SEND YOUR CLAIM TO PHARMACARE FOR PAYMENT.	CO	109
SJ	ACCORDING TO OUR RECORDS, WE DID NOT RECEIVE NOTIFICATION OF THIS SERVICE IN ADVANCE AS REQUIRED BY YOUR PLAN. THEREFORE, NO BENEFITS ARE AVAILABLE. IF YOU HAVE QUESTIONS, PLEASE CALL HEALTH INTERNATIONAL AT THE TELEPHONE NUMBER SHOWN ON YOUR ID CARD.	PR	62
SK	SERVICE INAPPROPRIATELY BILLED AS A PROFESSIONAL/TECHNICAL COMPONENT WAS REIMBURSED AS A GLOBAL SERVICE.	OA	
SL	THIS HEALTH CARE PROVIDER IS A PARTICIPATING PHYSICIAN WITH GROUP HEALTH INCORPORATED. THEREFORE, MAJOR MEDICAL BENEFITS ARE NOT AVAILABLE FOR THESE EXPENSES.	PR	96
SN	YOUR PLAN DOES NOT COVER MENTAL HEALTH AND/OR SUBSTANCE ABUSE SERVICES FOR SERVICES USING METHADONE TREATMENTS AS MAINTENANCE, L.A.A.M. (1-ALPHA-ACETYL-METHADOL), CYCLAZOCINE, OR THEIR EQUIVALENTS.	OA	96
SO	YOUR PLAN DOES NOT COVER OUTPATIENT SURGICAL EXPENSES.	PR	96
SP	YOUR PLAN DOES NOT COVER MENTAL HEALTH AND/OR SUBSTANCE ABUSE SERVICES PROVIDED IN CONNECTION WITH OR TO COMPLY WITH INVOLUNTARY COMMITMENTS, POLICE DETENTIONS, AND OTHER SIMILAR ARRANGEMENTS, UNLESS AUTHORIZED BY THE MENTAL HEALTH/SUBSTANCE ABUSE DESIGNEE.	OA	96
SQ	THIS PROCEDURE OR SUPPLY IS CONSIDERED INCLUDED IN THE OVERALL EVALUATION AND MANAGEMENT OF THE PATIENT. THE CHARGES RECEIVED	CO	57

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ST	ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT. PLEASE SUBMIT THE DENIAL STATEMENT FROM YOUR HIP/HMO CARRIER FOR THESE SERVICES.	PR	16
SV	THE NOT COVERED AMOUNT REPRESENTS THE ACTUAL PAYMENT OR AN ESTIMATED PAYMENT MADE BY A THIRD PARTY. IF THIS AMOUNT WAS NOT PAID BY A THIRD PARTY PAYOR, PLEASE SEND US THEIR DENIAL AND WE WILL REPROCESS YOUR CLAIM.	PR	22
SW	THIS AMOUNT IS MEDICARE'S PAYMENT PLUS ANY PORTION OF THE CHARGE THEY DID NOT APPROVE. BECAUSE THE PROVIDER AGREED TO ACCEPT ASSIGNMENT, THE PATIENT IS NOT RESPONSIBLE FOR PAYING ANY AMOUNT IN EXCESS OF WHAT MEDICARE APPROVED. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	CO	A2
SX	ACCORDING TO OUR RECORDS, YOUR SPOUSE IS ALSO COVERED UNDER A UNITEDHEALTHCARE GROUP HEALTH PLAN THAT IS PRIMARY TO YOUR COVERAGE. WE HAVE FORWARDED THIS CLAIM FOR PAYMENT UNDER THAT PLAN. IF THE BILL IS NOT PAID IN FULL, PLEASE SEND US THE EXPLANATION OF BENEFITS STATEMENT ALONG WITH THE BILL FOR CONSIDERATION UNDER THIS PLAN.	PR	22
SY	THIS CLAIM WAS SUBMITTED BY THE STATE AND IS FOR CHARGES THAT WERE PREVIOUSLY PAID UNDER MEDICAID.	PR	23
S0	OUR RECORDS SHOW WE HAVE ALREADY PROCESSED THIS CHARGE.	CO	18
S1	ACCORDING TO YOUR PLAN, MATERNITY CARE IS NOT COVERED UNDER YOUR MAJOR MEDICAL PLAN.	PR	96
S2	YOUR PLAN CONTAINS A PRE-EXISTING CONDITION LIMITATION. SINCE THESE EXPENSES RELATE TO A CONDITION THAT FALLS UNDER THE PRE-EXISTING LIMITATION, NO BENEFITS ARE AVAILABLE AT THIS TIME. IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CONTACT ONE OF OUR CUSTOMER CARE PROFESSIONALS AT THE NUMBER LISTED ABOVE.	PR	51
S5	ACCORDING TO OUR RECORDS, YOU DID NOT RECEIVE THE HIGHEST BENEFIT BECAUSE YOU DID NOT OBTAIN A SECOND OPINION PRIOR TO THIS SURGERY. YOUR BENEFIT IS LIMITED TO 80% OF THE AMOUNT ALLOWED. ACCORDING TO YOUR PLAN, THE REMAINING 20% IS NOT ELIGIBLE UNDER THE OUT-OF-POCKET FEATURE OF YOUR PLAN.	PR	61
S6	ACCORDING TO OUR RECORDS, THE OUT-OF-POCKET MAXIMUM AMOUNT HAS BEEN REACHED FOR THIS PLAN YEAR.	PR	2
S8	YOUR PLAN PROVIDES BENEFITS FOR SERVICES THAT ARE DETERMINED TO BE COVERED HEALTH SERVICES. THE INFORMATION RECEIVED DOES NOT SUPPORT MEASURABLE PROGRESS TOWARD DEFINED TREATMENT GOALS FOR THESE SERVICES. THEREFORE, ADDITIONAL BENEFITS ARE NOT AVAILABLE.	CO	50
S9	WE HAVE RECONSIDERED THESE LAB AND/OR DIAGNOSTIC CHARGES BASED ON ADDITIONAL INFORMATION WE RECEIVED AVAILABLE.		
TA	TOTAL ANESTHESIA MINUTES FOR THIS SERVICE EXCEED 999 MINUTES. FOR PROCESSING PURPOSES, IT WAS NECESSARY TO SPLIT THE TOTAL MINUTES AND THE CHARGE FOR THIS SERVICE INTO TWO SERVICE LINES.		
TB	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR REMOVAL OF AN ORGAN FOR PURPOSES OF TRANSPLANTATION INTO ANOTHER PERSON.	PR	96
TC	THIS PAYMENT REPRESENTS THE BENEFITS AVAILABLE UNDER GROUP POLICY CONTRACT GA-23000 FOR YOUR ON DUTY INJURY CLAIM. IF THIS CLAIM HAS BEEN SUBMITTED BY YOUR RAILROAD, ANY ADDITIONAL BENEFITS DUE WILL BE ISSUED UNDER POLICY GA-677576. IT IS NOT NECESSARY TO SUBMIT ANOTHER CLAIM.	CO	22
TD	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES WITH TRANSPLANTS INVOLVING MECHANICAL OR ANIMAL ORGANS.	PR	96
TE	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO THE FOLLOWING ADDRESS: P.O. BOX 660451, DALLAS, TX 75266-0451.		
TF	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO THE FOLLOWING ADDRESS: CASE INSTALLATION, 184 SHUMAN BLVD., NAPERVILLE, IL, 60563		
TG	IT HAS BEEN DETERMINED THAT ANOTHER INSURANCE CARRIER HAS PRIMARY PAYER RESPONSIBILITY FOR THESE SERVICES. PLEASE RESUBMIT THIS BILL TO THE OTHER INSURANCE CARRIER SO THEY CAN RECONSIDER THIS CHARGE. AFTER THEY COMPLETE THEIR REVIEW, PLEASE RESUBMIT THE CLAIM AND THE OTHER INSURANCE'S EXPLANATION OF BENEFITS TO US FOR PROCESSING.	CO	22
TH	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO THE FOLLOWING ADDRESS: CASE INSTALLATION,		

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TI	117 BUSINESS PARK DRIVE, UTICA, NY, 13502 YOUR PLAN DOES NOT COVER AMBULANCE SERVICES OR ASSOCIATED EXPENSES WHICH ARE NOT DUE TO AN EMERGENCY.	PR	96
TJ	YOUR PLAN PROVIDES BENEFITS FOR INJECTIONS RECEIVED IN A PHYSICIAN'S OFFICE WHEN NO OTHER HEALTH SERVICE IS RECEIVED. BECAUSE OTHER HEALTH SERVICES WERE RECEIVED, NO BENEFIT IS AVAILABLE FOR THIS INJECTION.	PR	96
TK	YOUR PLAN DOES NOT COVER THIS MATERNITY SERVICE AND/OR SUPPLY OR ASSOCIATED EXPENSE EXCEPT AS THE RESULT OF A COMPLICATION OF PREGNANCY.	PR	96
TL	BECAUSE YOUR PLAN DOES NOT COVER THESE SERVICES, WE DID NOT INVESTIGATE THIS CLAIM FOR PRE-EXISTING CONDITIONS. THIS DOES NOT WAIVE OUR RIGHT TO INVESTIGATE FUTURE CLAIMS.	PR	96
TM	YOUR PLAN DOES NOT PROVIDE BENEFITS FOR SERVICES RENDERED IN A PHYSICIAN'S OFFICE.	PR	58
TN	YOUR PLAN DOES NOT COVER THIS REHABILITATIVE OR THERAPEUTIC SERVICE OR ASSOCIATED EXPENSE.	PR	96
TO	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR INPATIENT SKILLED NURSING FACILITY OR INPATIENT REHABILITATION FACILITY SERVICES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
TP	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO THE FOLLOWING ADDRESS: 425 MARKET STREET, 14TH FL SAN FRANCISCO, CA 94105.		
TQ	THIS CLAIM HAS ALREADY BEEN PROCESSED AND THE ALLOWABLE AMOUNT WAS APPLIED TO THE YEARLY DEDUCTIBLE. THE PATIENT IS RESPONSIBLE FOR PAYMENT TO THE PHYSICIAN OR HEALTH CARE PROFESSIONAL.	PR	B13
TR	THIS REDUCTION IN CHARGE IS BASED ON A SPECIAL AGREEMENT BETWEEN THE HOME CARE ADVOCACY PROGRAM AND THE PROVIDER OF SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ORIGINAL CHARGE AND THE REDUCED AMOUNT.	PR	131
TT	YOUR PLAN CONTAINS A PRE-EXISTING CONDITION LIMITATION FOR THE FIRST SIX MONTHS OF COVERAGE. WE CONSIDERED YOUR CLAIM BASED ON THE INFORMATION WE RECEIVED. WE RESERVE THE RIGHT TO INVESTIGATE FUTURE CLAIMS.		
TU	THIS PATIENT IS NOT AN ELIGIBLE DEPENDENT UNDER YOUR PLAN.	PR	32
TV	WE HAVE FORWARDED YOUR OCCUPATIONAL INJURY CLAIM TO THE PROPER VENDOR FOR HANDLING. WHEN THAT VENDOR HAS COMPLETED PROCESSING OF YOUR CLAIM YOU WILL BE NOTIFIED.	OA	B11
TW	ACCORDING TO OUR RECORDS, THIS PAYMENT REFLECTS VALUEOPTIONS' CONTRACTED PER DAY PROGRAM RATE.	CO	A2
TX	FOR THIS DIAGNOSIS, SERVICES FROM THIS HEALTH CARE PROVIDER WILL BE COVERED FOR SIX VISITS. IF THESE SERVICES CONTINUE BEYOND SIX VISITS, THE SEVENTH AND ALL SUBSEQUENT VISITS MUST BE REVIEWED BY VALUEOPTIONS. PLEASE CONTACT VALUEOPTIONS AT 1-800-934-7245 IF THESE SERVICES CONTINUE.	CO	B11
TY	ACCORDING TO YOUR PLAN, THIS SERVICE ONLY WILL BE COVERED FOR SIX VISITS. THE SEVENTH AND ANY SUBSEQUENT VISITS WILL BE COVERED UNDER THE MH/SA PROGRAM ADMINISTERED BY VALUEOPTIONS. IF THESE VISITS CONTINUE, PLEASE CALL VALUEOPTIONS AT 1-800-934-7245.	CO	B11
TZ	THIS CLAIM HAS BEEN FORWARDED TO VALUEOPTIONS FOR REVIEW. NO FURTHER ACTION IS REQUIRED ON YOUR PART.	OA	B11
T0	SM PROGRAMS NETWORK PHYSICIAN/HOSPITAL. WE HAVE APPLIED THE CONTRACTED FEE. YOUR RESPONSIBILITY WAS REDUCED BECAUSE YOU CHOSE TO BE TREATED BY A PHYSICIAN/HOSPITAL THAT WAS APPROPRIATELY DESIGNATED IN THE UNITED HEALTH PREMIUM SM OR PERFORMANCE SM PROGRAMS. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN/HOSPITAL AND THE AMOUNT ALLOWED BY THE CONTRACT. THE PATIENT IS RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE, AND AMOUNTS OVER THE ANNUAL BENEFIT LIMITS FOR THIS SERVICE, UP TO THE ELIGIBLE EXPENSE.	CO	2
T1	YOUR PLAN DOES NOT COVER SERVICES OR EXPENSES FOR ECOLOGICAL OR ENVIRONMENTAL MEDICINE.	PR	96
T2	YOUR PLAN DOES NOT COVER MENTAL HEALTH AND/OR SUBSTANCE ABUSE SERVICES WHEN THEY ARE PROVIDED IN CONNECTION WITH CONDITIONS NOT CLASSIFIED IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF THE AMERICAN PSYCHIATRIC ASSOCIATION.	OA	96
T3	THE DIFFERENCE BETWEEN THE TOTAL COVERED CHARGE AND THE ABOVE BENEFITS WILL BE PROCESSED UNDER A SUPPLEMENTAL AGREEMENT. IT IS NOT NECESSARY TO SUBMIT ANOTHER CLAIM.	CO	22

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T4	ADDITIONAL BENEFITS MAY BE PAYABLE UNDER A SUPPLEMENTAL PLAN UPON RECEIPT OF AN AUTHORIZATION. PLEASE CONTACT THE APPROPRIATE PERSON AT YOUR EMPLOYER TO OBTAIN THE AUTHORIZATION.	OA	16
T5	YOUR PLAN CONTAINS A PRE-EXISTING CONDITION LIMITATION FOR THE FIRST 12 MONTHS OF COVERAGE. WE CONSIDERED YOUR CLAIM BASED ON THE INFORMATION WE RECEIVED. WE RESERVE THE RIGHT TO INVESTIGATE FUTURE CLAIMS.		
T6	YOUR CERTIFICATE OF COVERAGE CONTAINS A "STATEMENTS BY COVERED PERSONS" PROVISION REGARDING THE STATEMENTS MADE AT THE TIME OF APPLICATION. PLEASE NOTE THAT WE CONSIDERED YOUR CLAIM BASED ON INFORMATION WE RECEIVED. THIS DOES NOT WAIVE OUR RIGHT TO INVESTIGATE FUTURE CLAIMS.		
T7	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO THE FOLLOWING ADDRESS: CASE INSTALLATION, 2929 EXPRESS DRIVE NORTH, SUITE 300 HAUPPAUGE, NY 11788.		
T8	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO THE FOLLOWING ADDRESS: CASE INSTALLATION, 6700 SUGARLOAF PARKWAY, SUITE 100, DULUTH, GA 30097.		
T9	THIS IS A TEST DOCUMENT. PLEASE SEND THIS EXPLANATION OF BENEFITS STATEMENT TO CASE INSTALLATION, HO, 5PB.		
UA	ACCORDING TO OUR RECORDS, YOUR HEALTH CARE PROVIDER HAS AGREED TO LIMIT THE AMOUNT CHARGED FOR THIS SERVICE. THEREFORE, YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. HOWEVER, YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	OA	131
UB	YOU MUST SUBMIT AN ITEMIZED BILL WITH THE DATE OF SERVICE, SERVICE(S) PROVIDED, CHARGE FOR THE SERVICE, DIAGNOSIS, AND PHYSICIAN'S OR PROVIDER'S NAME AND ADDRESS. WE DO NOT ACCEPT OTHER RECEIPTS, BILLS, OR CANCELLED CHECKS AS PROOF OF MEDICAL EXPENSE.	OA	16
UC	YOUR HEALTH PLAN COVERS REASONABLE CHARGES INCURRED FOR THE THERAPEUTIC TREATMENT OF BODILY INJURY OR SICKNESS. THE AMOUNT ALLOWED FOR THESE SERVICES OR SUPPLIES WAS BASED ON THE AMOUNT USUALLY CHARGED BY OTHER LOCAL HEALTH CARE PROVIDERS FOR SIMILAR SERVICES OR SUPPLIES.	CO	45
UE	EMDX IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
UF	COMPLETE MEDICAL RECORDS ARE REQUIRED IN ORDER TO PROCESS THIS CLAIM.	OA	16
UG	WE HAVE APPLIED THIS PHYSICIAN'S OR HEALTH CARE PROFESSIONAL'S DISCOUNTED RATE TOWARDS YOUR DEDUCTIBLE. YOU HAVE NOT YET EXCEEDED YOUR DEDUCTIBLE AMOUNT PAYABLE.	PR	1
UH	STATE LAWS LIMIT HOW MUCH A PROVIDER MAY BILL FOR THE SERVICE(S) PERFORMED. WE HAVE EXCLUDED THE AMOUNT WE BELIEVE YOU ARE NOT REQUIRED TO PAY.	PR	96
UI	THIS CLAIM WAS SENT DIRECTLY TO US FOR PAYMENT. PREVIOUS CLAIMS FOR THIS INJURY WERE SENT TO YOUR EMPLOYER FOR PAYMENT. TO AVOID CONFUSION, PLEASE SEND THIS CLAIM TO YOUR EMPLOYER. IF YOU DO NOT WANT TO SEND THIS CLAIM TO YOUR EMPLOYER, PLEASE WRITE THAT ON THIS FORM AND RETURN IT TO US. IF YOU NEED A COPY OF THIS CLAIM, CALL THE TOLL FREE NUMBER.	PR	109
UJ	QMEDWORK IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
UK	ACCORDING TO OUR RECORDS, WE DID NOT RECEIVE PRIOR NOTIFICATION OF THESE SERVICES AS REQUIRED BY YOUR MEDICAL PLAN. HOWEVER, THIS CLAIM WAS PROCESSED AT THE NETWORK BENEFIT LEVEL. FUTURE SERVICES WITHOUT PRIOR NOTIFICATION WILL BE PROCESSED AT THE OUT-OF-NETWORK BENEFIT LEVEL.	CO	42
UL	THE AMOUNT CHARGED REPRESENTS THE AMOUNTS INDICATED ON THE MEDICARE EXPLANATION OF BENEFITS AND MAY NOT REFLECT THE CHARGE RECEIVED ON THE BILL. THE NOT COVERED AMOUNT REPRESENTS THE MEDICARE, OR PHYSICIAN OR OTHER HEALTH CARE PROVIDER ADJUSTMENT APPLIED TO THIS CHARGE. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	CO	22

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UM	ACCORDING TO YOUR PLAN ENROLLMENT REQUIREMENTS, YOU MUST ENROLL YOUR DEPENDENT WITHIN THE NUMBER OF DAYS SPECIFIED IN YOUR BENEFIT PLAN. IF YOU FAIL TO DO THIS, YOUR DEPENDENTS WILL NOT HAVE MEDICAL COVERAGE AS SOON AS PERMITTED UNDER THE PLAN. PLEASE CONTACT THE ELIGIBILITY AND ENROLLMENT DEPARTMENT IMMEDIATELY TO ENROLL YOUR DEPENDENT. ONCE YOU RECEIVE CONFIRMATION FROM THE ELIGIBILITY AND ENROLLMENT DEPARTMENT THAT YOUR DEPENDENT HAS BEEN ADDED AS A COVERED DEPENDENT RETURN THIS STATEMENT TO THE ADDRESS SHOWN AT THE TOP AND WE WILL RECONSIDER THE CLAIM.	PR	32
UO	THIS EXPENSE HAS BEEN PAID ACCORDING TO THE PROAMERICA/MULTIPLAN DISCOUNT AGREEMENT.	CO	A2
UP	THIS CLAIM CANNOT BE PROCESSED BECAUSE YOUR PROVIDER EITHER 1) DID NOT SUBMIT THE CLAIM WITHIN THE CONTRACTED TIME FRAME OR 2) SUBMITTED THE CLAIM BUT DID NOT SEND DETAILS ON WHY IT SHOULD BE REPROCESSED. IN SITUATION 1, YOU CANNOT BE BILLED FOR ANY AMOUNT OVER YOUR COPAY, COINSURANCE, OR DEDUCTIBLE. YOUR PROVIDER CAN ASK US TO RECONSIDER THE CLAIM BY DETAILING THE DATE THE CLAIM WAS ORIGINALLY FILED, ALONG WITH THIS EXPLANATION OF BENEFITS. IF THE SUBMISSION WAS ELECTRONIC, WE NEED A COPY OF THE ACCEPTANCE REPORT. IF SITUATION 2 OCCURRED, RESUBMIT WITH DETAILS OF WHY THE CLAIM SHOULD BE RECONSIDERED.	CO	29
UQ	THIS AMOUNT REPRESENTS 100% REIMBURSEMENT THROUGH THE SCHERING- PLOUGH PRESCRIPTION DRUG PLAN.	CO	42
UR	MEDICARE PAYS BENEFITS BEFORE YOUR GROUP HEALTH PLAN. SINCE THE PATIENT USED A FACILITY OF THE FEDERAL GOVERNMENT, WE PROCESSED THIS CLAIM AFTER ESTIMATING WHAT MEDICARE WOULD HAVE PAID FOR THE SERVICES OF A NON-GOVERNMENT FACILITY. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE BILLED CHARGE AND THE AMOUNT PAID BY THIS PLAN.	PR	22
US	ACCORDING TO OUR RECORDS, THIS PATIENT IS NOT COVERED BY UNITEDHEALTHCARE. THEREFORE, BENEFITS ARE NOT AVAILABLE. PLEASE CONTACT THE PATIENT FOR ADDITIONAL INFORMATION REGARDING HIS OR HER CURRENT BENEFITS ADMINISTRATOR. IF YOU ARE THE GE ENROLLEE, PLEASE CONTACT THE GE ENROLLMENT CENTER.	PR	31
UT	ACCORDING TO OUR RECORDS, THIS SERVICE IS NOT FOR THE DIRECT CARE OR TREATMENT OF THE PATIENT. THEREFORE, ACCORDING TO YOUR PLAN, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE.	CO	96
UW	MEDICARE DID NOT APPROVE THIS SERVICE AND INDICATES YOU ARE NOT RESPONSIBLE FOR THE EXPENSE. SINCE YOU HAVE NO RESPONSIBILITY FOR THIS EXPENSE, YOUR PLAN HAS NO BALANCE TO CONSIDER.	CO	96
UX	THE PROCEDURE CODE MODIFIER SUBMITTED HAS ALREADY BEEN CONSIDERED AND PROCESSED FOR THIS SERVICE. BASED ON THE PATIENT'S CLAIM HISTORY, NO FURTHER BENEFITS ARE AVAILABLE FOR THIS SERVICE.	OA	B20
UY	SINCE WE DID NOT RECEIVE A BILL FOR AN ASSOCIATED MEDICAL/SURGICAL SERVICE, THE OFFICE BASED MEDICAL SUPPLIES ARE NOT COVERED.	PR	96
UZ	THE UNITEDHEALTHCARE DIAGNOSTIC IMAGING PROGRAM GUIDELINES INDICATE THAT THE HEALTH CARE PROVIDER IS NOT PERMITTED TO PERFORM THIS SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THIS AMOUNT.	OA	170
U0	YOUR BENEFIT PLAN DOES NOT REIMBURSE FOR A SECOND ASSISTANT SURGEON. ONLY ONE ASSISTANT SURGEON IS ELIGIBLE FOR EACH PROCEDURE.	CO	54
U1	YOUR PLAN COVERS REASONABLE CHARGES INCURRED FOR THE THERAPEUTIC TREATMENT OF BODILY INJURY OR SICKNESS. THE AMOUNT ALLOWED FOR THESE SERVICES IS BASED ON THE RANGE OF FEES CHARGED BY THE PROVIDERS IN YOUR GEOGRAPHICAL AREA.	CO	45
U2	IG/HPO/INTER HLTH PLAN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
U3	THE NOT COVERED AMOUNT IS THE AMOUNT PAID BY YOUR DENTAL PLAN.	PR	23
U4	THE NOT COVERED AMOUNT REPRESENTS EXPENSES COVERED BY YOUR BASIC BENEFITS INSURANCE PLAN.	PR	23
U5	MEDICAL EXPENSES NOT PAID OR COVERED ON THIS CLAIM WILL BE CONSIDERED UNDER YOUR EMPLOYER MEDICAL REIMBURSEMENT PLAN.	PR	22
U6	YOUR PLAN DOES NOT COVER MENTAL HEALTH AND/OR SUBSTANCE ABUSE SERVICES THAT EXTEND BEYOND THE PERIOD NECESSARY FOR SHORT-TERM EVALUATION, DIAGNOSIS, TREATMENT, OR CRISIS INTERVENTION.	PR	96
U7	ACCORDING TO OUR RECORDS, THESE CHARGES ARE FOR SERVICES RECEIVED PRIOR TO THE ESTABLISHED BENEFIT PERIOD.	PR	26
U9	ACCORDING TO OUR RECORDS, YOU ARE NOT COVERED UNDER THIS HEALTH	OA	31

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	INSURANCE PLAN. PLEASE CONTACT YOUR EMPLOYER TO DETERMINE THE APPROPRIATE CARRIER.		
VA	THANK YOU FOR CONTACTING THE CARE COORDINATION PROGRAM REGARDING YOUR RECENT HOSPITALIZATION.		
VB	THESE CHARGES WERE INCORRECTLY PAID BY MEDICARE AS PRIME CARRIER. WE HAVE REDUCED THIS PAYMENT BY THE AMOUNT PREVIOUSLY PAID BY MEDICARE AND ISSUED REPAYMENT DIRECTLY TO MEDICARE TO THE EXTENT OF THE PLAN'S LIABILITY. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE TOTAL BILLED AMOUNTS ON THIS STATEMENT AND THE AMOUNTS PAID BY THIS PLAN AND MEDICARE AS INDICATED ON THEIR STATEMENT. MEDICARE COULD BE RE-BILLED FOR ANY BALANCE ONCE THEY HAVE ADJUSTED THEIR RECORDS TO INDICATE THEY ARE THE SECONDARY PAYER.		
VC	INDEPENDENT MED SYSTEMS IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
VE	CAI & MEDLINK HEALTHCARE IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
VH	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR MEGAVITAMIN THERAPY.	PR	96
VI	YOUR MENTAL HEALTH AND SUBSTANCE ABUSE PLAN REQUIRES THAT YOU NOTIFY THEM PRIOR TO RECEIVING SERVICES. BECAUSE YOU HAVE SEEN A NON-NETWORK PHYSICIAN OR HEALTH CARE PROVIDER AND DID NOT NOTIFY YOUR PLAN PRIOR TO RECEIVING THESE SERVICES, YOUR BENEFITS HAVE BEEN REDUCED AND A PENALTY HAS BEEN APPLIED. PLEASE CONTACT YOUR MENTAL HEALTH AND SUBSTANCE ABUSE CARRIER LISTED ON YOUR ID CARD PRIOR TO RECEIVING ANY FUTURE SERVICES.	PR	62
VJ	THANK YOU FOR CHOOSING A PHYSICIAN OR OTHER HEALTH CARE PROVIDER IN YOUR NETWORK. YOU RECEIVE HIGHER LEVEL OF BENEFITS WHEN YOU COORDINATE YOUR CARE THROUGH YOUR PRIMARY PHYSICIAN.	CO	A2
VL	ACCORDING TO OUR RECORDS, YOUR BENEFITS ARE LOWER BECAUSE THE NOTIFICATION WE HAVE ON FILE IS FOR A SIMILAR BUT LESS INTENSIVE SERVICE.	PR	62
VM	WE RECEIVED YOUR CLAIM BUT CANNOT PROCESS IT AT THIS TIME. PLEASE REFER TO OUR CORRESPONDENCE TO THE MEMBER REGARDING DEPENDENT/STUDENT VERIFICATION. WE NEED THIS INFORMATION TO PROCESS YOUR CLAIM.	OA	16
VN	THIS PAYMENT SUPPLEMENTS BENEFITS PAID UNDER THE RAILROAD EMPLOYEES NATIONAL HEALTH AND WELFARE PLAN FOR AN ON-DUTY INJURY.	CO	42
VO	ACCORDING TO OUR RECORDS, A VALID REFERRAL WAS REQUIRED, BUT NOT OBTAINED. THEREFORE, WE ARE NOT RESPONSIBLE FOR PAYMENT.	PR	62
VP	A PRIOR NOTIFICATION WAS REQUIRED BUT NOT RECEIVED, THEREFORE NO BENEFITS ARE PAYABLE.	PR	62
VQ	THIS SERVICE MUST BE REPORTED WITH AN ANESTHESIA SERVICE.	CO	B15
VR	ACCORDING TO YOUR PLAN, A VALID AUTHORIZATION WAS REQUIRED, BUT NOT OBTAINED. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	62
VS	OVER-THE-COUNTER DRUGS ARE NOT COVERED.	PR	96
VT	PLEASE REFER THIS CHARGE TO THE CAPITATED ORGANIZATION/IPA LISTED DIRECTLY ABOVE FOR PROCESSING. THE PATIENT HAS NO FINANCIAL RESPONSIBILITY EXCEPT FOR THE COPAY AMOUNT, WHEN APPLICABLE.	OA	24
VU	THIS CHARGE HAS BEEN PROCESSED ON BEHALF OF YOUR CAPITATED IPA ORGANIZATION.	OA	24
VV	THIS CHARGE HAS BEEN PROCESSED ON BEHALF OF A CAPITATED IPA ORGANIZATION.	OA	24
VW	THANK YOU FOR USING UNITED HEALTHCARE.	CO	A2
VX	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR PSYCHOSURGERY.	PR	96
VY	THE FACTOR AMOUNT SHOWN ON THIS CHARGE (NET ALLOWED) WAS CALCULATED USING A FACTOR (ADJ FACTOR) THAT IS DETERMINED ON A PERIODIC BASIS AND RELATES TO DATES OF SERVICE FOR THIS CHARGE.	OA	24
VZ	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR NUTRITIONAL-BASED THERAPY.	PR	96
VO	AS A RESULT OF AN EXAM BY THE VA BOI, THIS CLAIM WAS UNDERPAID AND ADJUSTED.	CO	45

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V1	THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE AMOUNTS AND AMOUNTS OVER THE ANNUAL BENEFIT LIMITS FOR THIS SERVICE, UP TO THE ELIGIBLE EXPENSE.	CO	A2
V2	PAID ACCORDING TO ERS FOR WHICH THE DISCOUNT WAS ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-866-459-7202 FOR ASSISTANCE.	CO	A2
V3	THE EXCLUDED AMOUNT REPRESENTS YOUR HOSPITAL DEDUCTIBLE.	PR	1
V4	YOUR BENEFITS ARE LOWER BECAUSE WE DID NOT RECEIVE NOTIFICATION FOR THIS HOSPITAL STAY. FOR MORE INFORMATION PLEASE CONTACT US USING THE NUMBER LISTED ON YOUR ID CARD.	PR	62
V5	YOUR BENEFITS ARE LOWER BECAUSE YOU WERE ADMITTED PRIOR TO THE DATE INDICATED DURING THE NOTIFICATION PROCESS.	PR	62
V6	BENEFITS ARE PAYABLE ONLY FOR SERVICES PROVIDED FOR THE LENGTH OF STAY INDICATED DURING THE NOTIFICATION PROCESS. IF YOU HAVE QUESTIONS, PLEASE CONTACT US AT THE TELEPHONE NUMBER ON YOUR ID CARD.	PR	62
V7	WE HAVE RECONSIDERED THESE CHARGES AND HAVE REPROCESSED THE CLAIM IN ACCORDANCE WITH YOUR INTEL PLAN. AS A RESULT, YOUR APPEAL WILL NOT BE FORWARDED TO MRI FOR REVIEW.		
V9	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
WA	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE MODIFIER AND CHARGE.	CO	B15
WB	PLEASE NOTE: AS OF JUNE 21, PLEASE MAIL ALL CLAIMS TO PO BOX 473500, CHARLOTTE, NC 28247-3500. ALSO, AS OF JUNE 21, PLEASE DIRECT ALL PHONE INQUIRIES TO 1-800-331-6473.	CO	109
WC	COLUMBIA GAS EMPLOYEES, PLEASE NOTE: AS OF JUNE 21, PLEASE MAIL ALL CLAIMS TO PO BOX 700, VOORHEES, NJ 08043. ALSO AS OF JUNE 21, PLEASE DIRECT ALL PHONE INQUIRIES TO 1-800-847-4733.	CO	109
WD	THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT. THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE MODIFIER AND CHARGE.	CO	B15
WE	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE AND ANESTHESIA MINUTES.	CO	B15
WF	ADDITIONAL INFORMATION REQUESTED FROM THE MEMBER HAS NOT BEEN RECEIVED. PLEASE CONSIDER THIS AN OFFICIAL DENIAL OF THE CHARGES INDICATED IN THE PATIENT RESPONSIBILITY FIELD.	OA	16
WG	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA SERVICE CODE FOR CLAIM PROCESSING PURPOSES. THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES AND/OR PHYSICAL STATUS MODIFIERS WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE AND ANESTHESIA MINUTES.	CO	B15
WH	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE, PROCEDURE CODE MODIFIER, AND ANESTHESIA MINUTES.	CO	B15
WI	ENCORE COMPUTERS EMPLOYEES, PLEASE NOTE: AS OF JUNE 21, PLEASE MAIL ALL CLAIMS TO PO BOX 740122, ATLANTA, GA 30374-0122. ALSO AS OF JUNE 21, PLEASE DIRECT ALL PHONE INQUIRIES TO 1-800-826-2211.	CO	109
WJ	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA SERVICE CODE FOR CLAIM PROCESSING PURPOSES. THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT. THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES AND/OR PHYSICAL STATUS MODIFIERS WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE/ MODIFIER, AND ANESTHESIA MINUTES.	CO	B15
WK	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE AND PROCEDURE CODE MODIFIER.	CO	B15
WL	THIS PROVIDER HAS ACCEPTED A DISCOUNT ON YOUR BILL. YOU ARE ONLY RESPONSIBLE TO PAY THE AMOUNT SHOWN AS PATIENT PAYS. IF YOU ALREADY PAID THIS BILL, YOU SHOULD ASK THE PROVIDER FOR A REFUND OF THE	OA	131

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	DISCOUNTED AMOUNT.		
WM	WE REPROCESSED YOUR CLAIM BASED ON ADDITIONAL INFORMATION THAT WAS PROVIDED BY ENCOMPASS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ENCOMPASS AT 1(888)781-9458. ENCOMPASS HAS BEEN RETAINED BY CHICAGO PUBLIC SCHOOLS AND IS NOT AFFILIATED WITH UNITEDHEALTHCARE.		
WN	THIS IS AN ADJUSTMENT DUE TO A COPAY/COINSURANCE LAW.	CO	3
WO	ACCORDING TO YOUR PLAN, NEWBORN CHARGES FOR WELL BABIES ARE CONSIDERED UNDER THE MOTHER'S CLAIM.	OA	128
WP	THIS CLAIM FOR MENTAL HEALTH/SUBSTANCE ABUSE WAS MISDIRECTED TO OUR OFFICE. PLEASE SEND THIS AND ALL FUTURE CLAIMS FOR MENTAL HEALTH/SUBSTANCE ABUSE DIRECTLY TO YOUR PLAN'S MENTAL HEALTH/SUBSTANCE ABUSE ADMINISTRATOR.	OA	109
WQ	THE EXCLUDED AMOUNT IS ABOVE THE CHARGE DETERMINED TO BE A REASONABLE FEE BY UNITEDHEALTHCARE OR ABOVE THE STATE STATUTORY AMOUNT FOR THE PHOTOCOPYING AND SUPPLYING OF MEDICAL RECORDS. IF THESE RECORDS WERE PROVIDED BY A COPY VENDOR, ANY BALANCE DUE SHOULD BE REFERRED TO THE PHYSICIAN OR MEDICAL PROVIDER WHO REQUESTED THE COPY SERVICES.	CO	96
WR	ADJUSTMENT DUE TO A COLORADO COPAY LAW.	CO	3
WT	ROUTINE EXAMS AND/OR RELATED SERVICES ARE NOT A COVERED EXPENSE UNDER YOUR GROUP HEALTH PLAN UNLESS THE SERVICES WERE PERFORMED BY A NETWORK PROVIDER.	PR	38
WU	THIS PROVIDER IS BARRED FROM PARTICIPATING IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP). YOU ARE RESPONSIBLE FOR PAYING ALL CHARGES. PLEASE REFER TO THE LETTER WE SENT TO YOU DESCRIBING WHEN EXCEPTIONS MAY OCCUR.	PR	96
WV	THIS EXPENSE HAS BEEN REVIEWED BY MANAGED HEALTH NETWORK, ANY QUESTIONS REGARDING COVERED EXPENSES SHOULD BE REFERRED TO 1-800-777-7991.	CO	109
WW	WE RECEIVED YOUR CLAIM. WE CANNOT PROCESS IT AT THIS TIME BECAUSE WE ARE STILL WAITING FOR INFORMATION ABOUT OTHER INSURANCE COVERAGE. PLEASE REFER TO THE CORRESPONDENCE DIRECTED TO THE ENROLLEE REGARDING THIS MATTER. WHEN WE RECEIVE THIS INFORMATION, WE WILL COMPLETE THE PROCESSING OF YOUR CLAIM. IF THIS INFORMATION HAS ALREADY BEEN SENT TO US, PLEASE DISREGARD THIS MESSAGE. WE WILL UPDATE YOUR RECORDS AS QUICKLY AS POSSIBLE AND REPROCESS ALL CLAIMS AWAITING THIS INFORMATION.	PR	16
WX	THIS CLAIM HAS BEEN REPROCESSED BASED ON INFORMATION RECEIVED FROM COUGHLAN KUKANOS COOK, LLC. IF YOU HAVE ANY QUESTIONS REGARDING THE SPECIFIC PROCESSING OF YOUR CLAIM, PLEASE CALL UNITEDHEALTHCARE AT THE NUMBER LISTED ON THIS EXPLANATION OF BENEFITS. IF YOU WISH TO CONTACT COUGHLAN KUKANOS COOK, LLC, TO DISCUSS THEIR REVIEW PROCESS, PLEASE CALL 1-312-357-9200.		
WY	WE DO NOT SHOW COVERAGE FOR YOU AT THE TIME THIS CLAIM WAS SUBMITTED. IF YOU ARE ON COBRA AND MADE THE PREMIUM PAYMENT, PLEASE CONTACT THE CLAIM OFFICE. WE APOLOGIZE FOR ANY DELAY OR INCONVENIENCE YOU MAY EXPERIENCE.	OA	27
WZ	IN ORDER TO COMPLETE THE PROCESSING OF THIS CLAIM, WE NEED THE MEDICARE CONTRACTUAL ADJUSTMENT FOR THIS CHARGE. PLEASE INDICATE THE MEDICARE CONTRACTUAL ADJUSTMENT AT THE BOTTOM OF THIS STATEMENT AND RETURN IT TO US AT THE ADDRESS LISTED ABOVE.	OA	16
W0	INTEREST HAS BEEN PAID ON THIS CLAIM BECAUSE OF AN EXAMINATION BY THE COLORADO DEPARTMENT OF INSURANCE.	CO	85
W1	THESE EXPENSES HAVE BEEN APPLIED TO THE PATIENT'S ANNUAL DEDUCTIBLE. THE PATIENT IS RESPONSIBLE FOR PAYING THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL ALL CHARGES THAT ARE APPLIED TO THE ANNUAL DEDUCTIBLE PLEASE FORWARD THIS PAYMENT TO YOUR PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.	PR	1
W2			
W3			
W4	IF YOU HAVE SATISFIED ALL OR ANY PORTION OF YOUR DEDUCTIBLE WITH YOUR PREVIOUS CARRIER, PLEASE SUBMIT THE WORKSHEET SHOWING THE AMOUNT OF THE DEDUCTIBLE TAKEN. WE WILL CONSIDER THAT AMOUNT TOWARD YOUR DEDUCTIBLE.	CO	1
W5	PROMPT PAYMENT PENALTY BASED ON PROVIDER CONTRACT PROVISIONS.	OA	96
W6	ACCORDING TO YOUR CARE TRUST CONTRACT, A COPY OF THE INVOICE MUST BE PROVIDED IN ORDER TO DETERMINE THE CORRECT CONTRACTED RATE FOR THIS REVENUE CODE. PLEASE SUBMIT TO UNITEDHEALTHCARE, H.E.A.T. UNIT, P.O. BOX 30565, SALT LAKE CITY, UT 84130.	OA	16

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W7	ACCORDING TO YOUR CARE TRUST CONTRACT, AN ITEMIZED BILL AND/OR NDC NUMBERS MUST BE PROVIDED IN ORDER TO DETERMINE THE CORRECT CONTRACTED RATE FOR THIS CLAIM. PLEASE SUBMIT TO UNITEDHEALTHCARE, H.E.A.T. UNIT, P.O. BOX 30565, SALT LAKE CITY, UT 84130.	OA	16
W8	THE NOT COVERED AMOUNT IS THE DISCOUNT ALLOWED YOUR COMPANY BY THIS PROVIDER. THE MEMBER IS NOT RESPONSIBLE FOR THE NOT COVERED AMOUNT.	OA	131
W9	THIS HAS BEEN GRANTED AS A ONE TIME EXCEPTION.	CO	42
XA	THIS CONDITION IS OF A MEDICAL NATURE AND IS NOT COVERED BY YOUR VISION POLICY. PLEASE SUBMIT THIS EXPENSE TO YOUR HEALTH BENEFIT PLAN.	CO	109
XB	YOUR PLAN COVERS ONE PAIR OF EYE GLASSES OR CONTACT LENSES AFTER CATARACT SURGERY WHEN ORDERED BY A PHYSICIAN.		
XC	YOUR PLAN DOES NOT COVER MENTAL HEALTH/SUBSTANCE ABUSE SERVICES FOR THE TREATMENT OF INSOMNIA AND OTHER SLEEP DISORDER, DEMENTIA, NEUROLOGICAL DISORDERS, AND OTHER DISORDERS WITH A KNOWN PHYSICAL BASIS.	PR	96
XD	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE, PROCEDURE CODE MODIFIER, AND CHARGE.	CO	B15
XE			
XF			
XG	YOUR MEDICARE CARRIER IS STILL CONSIDERING THIS SERVICE. PLEASE REFER TO THE EXPLANATION OF BENEFITS RECEIVED FROM YOUR MEDICARE CARRIER FOR EXPLANATION. PLEASE RESUBMIT THIS SERVICE ONCE MEDICARE HAS COMPLETED THEIR REVIEW.	OA	16
XH	YOUR MEDICARE CARRIER IS STILL CONSIDERING THIS SERVICE. PLEASE REFER TO THE EXPLANATION OF BENEFITS RECEIVED FROM YOUR MEDICARE CARRIER FOR EXPLANATION. WE WILL PROCESS THIS SERVICE ONCE MEDICARE HAS COMPLETED THEIR REVIEW.	OA	16
XI	THE PLAN PAYS THE 34.82% SURCHARGE AS REQUIRED BY THE NEW YORK HEALTH CARE REFORM ACT. THE PATIENT IS RESPONSIBLE FOR PAYING THE 34.82% SURCHARGE ON ANY CHARGES SHOWN AS PATIENT PAYS/PATIENT RESP. IN ADDITION TO THE 34.82% SURCHARGE ON ANY CHARGES SHOWN AS NOT COVERED. THE ADDITIONAL SURCHARGE WILL BE BILLED BY YOUR PROVIDER. (FOR DATES OF SERVICE PRIOR TO 07/01/03, 32.18% APPLIES.)	CO	137
XJ	THE PLAN PAYS AN ADDITIONAL SURCHARGE FOR IN-HOSPITAL SERVICES AS REQUIRED BY THE NEW YORK HEALTH CARE REFORM ACT.	CO	137
XK	THIS CLAIM HAS BEEN SUBMITTED TO THE INCORRECT CLAIM OFFICE. THIS IS NOT A CLAIM DENIAL AND NO ACTION IS REQUIRED OF THE MEMBER. ALL CLAIMS FOR THIS PATIENT FOR TRANSPLANT OR CANCER RESOURCE SERVICES (CRS) MUST BE SUBMITTED TO THE UNITED RESOURCE NETWORKS (URN) AT UNITED RESOURCE NETWORKS, P.O. BOX 30758, SALT LAKE CITY, UT 84130.	OA	109
XM	THIS SERVICE IS BEING RECODED TO REVISE THE CHARGE.	CO	B15
XO	THE CHARGE FOR THIS SERVICE IS THE COMBINED CHARGE FOR ALL SERVICES SUBMITTED FOR THIS PRIMARY OR GLOBAL PROCEDURE. WE HAVE BASED REIMBURSEMENT ON THE REVISED CHARGE.	CO	B15
XQ	THIS SERVICE WAS BILLED WITH A NUMBER OF UNITS WHICH WE ASSUME IS INCORRECT BECAUSE IT EXCEEDS THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE. THIS SERVICE IS REPLACED BY THE SAME PROCEDURE CODE AND CHARGE BUT WITH ADJUSTED UNITS.	CO	151
XR	THIS SERVICE REPLACED A SERVICE WHICH WAS BILLED WITH UNITS OVER THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE. THIS SERVICE USES THE SAME PROCEDURE CODE AND CHARGES AS THE ORIGINAL BUT ASSUMES THAT THE NUMBER OF UNITS IS THE TYPICAL FREQUENCY PER DAY. THE BENEFITS ARE BASED ON THIS QUANTITY. IF THE PROVIDER HAS ADDITIONAL DOCUMENTATION, PLEASE SEND IT TO US FOR CONSIDERATION.		
XS	THE INITIAL OFFICE VISIT CODE WAS CHANGED TO A SUBSEQUENT OFFICE VISIT CODE BECAUSE OUR RECORDS SHOW THAT THIS PATIENT HAS BEEN SEEN BY THIS PROVIDER BEFORE.	CO	150
XT	THIS SERVICE REPLACES A SERVICE BILLED INAPPROPRIATELY AS A NEW PATIENT VISIT. OUR RECORDS INDICATE THAT THERE HAS BEEN A PREVIOUS VISIT AND WE HAVE REVISED THE PROCEDURE CODE TO REFLECT AN ESTABLISHED PATIENT VISIT.		
XU	THIS SERVICE IS NOT REIMBURSEABLE FOR THIS PROVIDER IN THIS PLACE OF SERVICE.	CO	171
XV	THIS SERVICE IS NOT COVERED AS YOU DID NOT USE HOSPITAL ASSOCIATION FACILITIES WHENEVER POSSIBLE.	PR	96
XW	PLEASE REFER TO THE REMARK REGARDING THE SURCHARGE REQUIRED BY	CO	137

United Platform Proprietary Code	United Platform Proprietary Description	ANSI Claim Adjustment Group Code	ANSI Claim Adjustment Reason Code
XX	THE NEW YORK HEALTH CARE REFORM ACT. THE PLAN WILL PAY AN 8.85% SURCHARGE DIRECTLY TO NEW YORK STATE FOR BENEFITS PAID AND ANY DEDUCTIBLE/COPAY APPLIED. THE PATIENT IS RESPONSIBLE TO PAY THE 8.85% SURCHARGE FOR ANY PATIENT COINSURANCE OR OTHER BALANCE DUE AMOUNTS. THE PROVIDER WILL BILL THE PATIENT FOR THE SURCHARGE ON BALANCE DUE AMOUNTS. (FOR DATES OF SERVICE PRIOR TO 07/01/03, 8.18% APPLIES.)	CO	137
XY	THIS SERVICE IS BEING RECODED TO REVISE THE ANESTHESIA MINUTES.	CO	B15
XZ	THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES AND/OR PHYSICAL STATUS MODIFIERS WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED ANESTHESIA MINUTES.	CO	B15
X0	THIS ANESTHESIA SERVICE HAS BEEN RECODED TO AN EQUIVALENT ANESTHESIA SERVICE CODE FOR CLAIM PROCESSING PURPOSES. THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE/MODIFIER.	CO	B15
X1	YOU HAVE REACHED THE VISION BENEFIT MAXIMUM FOR THIS SERVICE.	PR	35
X2	YOUR VISION CARE PLAN PROVIDES FOR REASONABLE AND CUSTOMARY EXPENSES INCURRED FOR THIS SERVICE UP TO THE AMOUNT SPECIFIED IN THE SCHEDULE OF VISION SERVICES.	PR	45
X3	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE MODIFIER AND ANESTHESIA MINUTES.	CO	B15
X4	THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT. THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES AND/OR PHYSICAL STATUS MODIFIERS WHEN SUBMITTED. WE HAVE BASED REIMBURSEMENT ON THE REVISED PROCEDURE CODE MODIFIER AND ANESTHESIA MINUTES.	CO	B15
X5	YOUR BENEFIT PLAN REQUIRES CERTAIN SERVICES BE PRE-CERTIFIED. BENEFITS HAVE BEEN REDUCED IN WHOLE OR IN PART BECAUSE THESE SERVICES WERE NOT PRE-CERTIFIED BY ENCOMPASS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ENCOMPASS AT 1(800)781-9458. ENCOMPASS HAS BEEN RETAINED BY CHICAGO	PR	62
X6	YOUR BENEFIT PLAN REQUIRES CERTAIN SERVICES BE PRE-CERTIFIED. BENEFITS HAVE BEEN REDUCED IN WHOLE OR IN PART BECAUSE YOUR CONFINEMENT EXCEEDED THE LENGTH OF STAY RECOMMENDED BY ENCOMPASS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ENCOMPASS AT 1(800)781-9458. ENCOMPASS HAS BEEN RETAINED BY CHICAGO PUBLIC SCHOOLS AND IS NOT AFFILIATED WITH UNITEDHEALTH.	PR	62
X7	YOUR BENEFIT PLAN REQUIRES CERTAIN SERVICES BE PRE-CERTIFIED. BENEFITS HAVE BEEN REDUCED IN WHOLE OR IN PART BECAUSE THIS SERVICE WAS NOT MEDICALLY INDICATED BY ENCOMPASS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL ENCOMPASS AT 1(800)781-9458. ENCOMPASS HAS BEEN RETAINED BY CHICAGO PUBLIC SCHOOLS AND IS NOT AFFILIATED WITH UNITEDHEALTHCARE.	PR	62
X8	THIS PROCEDURE CODE AND MODIFIER ARE THE SAME AS OR EQUIVALENT TO ANOTHER PROCEDURE CODE AND MODIFIER PREVIOUSLY SUBMITTED BY ANOTHER HEALTH CARE PROVIDER. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS	CO	18
X9	THIS PROCEDURE CODE AND MODIFIER ARE THE SAME AS OR EQUIVALENT TO ANOTHER PROCEDURE CODE AND MODIFIER SHOWN ON THIS SAME CLAIM SUBMISSION OR A PRIOR CLAIM SUBMISSION. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS SERVICE.	CO	18
YA	BASED ON INFORMATION PROVIDED THE SERVICE IS NOT SUPPORTED BY NATIONAL MEDICAL STANDARDS OF PRACTICE. THEREFORE BENEFITS ARE NOT AVAILABLE.	CO	50
YB	THIS CLAIM WAS PREVIOUSLY SUBMITTED/CONSIDERED. WE DETERMINED THAT THE CLAIM CANNOT BE PROCESSED. YOUR PROVIDER 1)DID NOT SUBMIT THE CLAIM WITHIN THE CONTRACTED TIME FRAME OR 2)SUBMITTED THE CLAIM BUT DID NOT SEND DETAILS ON WHY IT SHOULD BE REPROCESSED. IN SITUATION 1, YOU CANNOT BE BILLED FOR AMOUNTS OVER YOUR COPAY, COINSURANCE OR DEDUCTIBLE. YOUR PROVIDER CAN ASK US TO RECONSIDER THE CLAIM BY DETAILING THE DATE THE CLAIM WAS ORIGINALLY FILED, ALONG WITH THIS EOB. IF THE SUBMISSION WAS ELECTRONIC, WE NEED A COPY OF THE ACCEPTANCE REPORT. IF SITUATION 2, RESUBMIT WITH DETAILS OF WHY THE CLAIM SHOULD BE RECONSIDERED.	CO	18
YF	OUR RECORDS INDICATE YOUR COVERAGE IS PROVIDED BY PRUDENTIAL HEALTHCARE. THIS AND ANY FUTURE CLAIMS SHOULD BE SUBMITTED DIRECTLY TO PRUDENTIAL HEALTHCARE P.O. BOX 44039	OA	27

United Platform Proprietary Code	United Platform Proprietary Description	ANSI Claim Adjustment Group Code	ANSI Claim Adjustment Reason Code
	JACKSONVILLE, FL 32231-4039 TELEPHONE # 1-888-268-8725		
YG	BASED ON THE INFORMATION PROVIDED, THIS SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL AND IS NOT COVERED. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT SCIENTIFIC EVIDENCE, THAT MEETS THE STANDARDS DESCRIBED IN YOUR BENEFIT PLAN LANGUAGE, THAT DEMONSTRATES THE SAFETY AND EFFECTIVENESS OF THIS SERVICE FOR YOUR PARTICULAR CONDITION.	PR	55
YH	THIS CLAIM WAS PREVIOUSLY SUBMITTED/CONSIDERED. WE DETERMINED THAT THE CLAIM CANNOT BE PROCESSED. YOUR PROVIDER 1)DID NOT SUBMIT THE CLAIM WITHIN THE CONTRACTED TIME FRAME OR 2)SUBMITTED THE CLAIM BUT DID NOT SEND DETAILS ON WHY IT SHOULD BE REPROCESSED. IN SITUATION 1, YOU CANNOT BE BILLED FOR AMOUNTS OVER YOUR COPAY, COINSURANCE OR DEDUCTIBLE. YOUR PROVIDER CAN ASK US TO RECONSIDER THE CLAIM BY DETAILING THE DATE THE CLAIM WAS ORIGINALLY FILED, ALONG WITH THIS EOB. IF THE SUBMISSION WAS ELECTRONIC, WE NEED A COPY OF THE ACCEPTANCE REPORT. IF SITUATION 2, RESUBMIT WITH DETAILS OF WHY THE CLAIM SHOULD BE RECONSIDERED.	CO	18
YI	THIS CLAIM WAS PREVIOUSLY SUBMITTED AND CONSIDERED. IT WAS DETERMINED THAT YOUR CLAIM WAS NOT SUBMITTED WITHIN THE TIME FRAME SPECIFIED IN YOUR PLAN DOCUMENTS OR CONTRACT. CONSEQUENTLY, WE ARE UNABLE TO CONSIDER IT FOR PAYMENT. PLEASE REFER TO YOUR PLAN DOCUMENT OR CONTRACT SPECIFIC REQUIREMENTS FOR ADDITIONAL INFORMATION ON PERMISSIBLE TIME FRAMES FOR SUBMITTING CLAIMS.	CO	18
YJ	THE EXCLUDED AMOUNT IS THE DIFFERENCE BETWEEN THE PROVIDER'S CONTRACTED RATE WITH HEALTHPOINT AND THE AMOUNT BILLED. YOU ARE NOT RESPONSIBLE FOR PAYING THIS AMOUNT. PLEASE CONTACT THE PROVIDER FOR A REFUND IF YOU HAVE ALREADY PAID.	CO	A2
YL	THIS CLAIM HAS BEEN PROCESSED IN ACCORDANCE WITH THE NEGOTIATED CONTRACT RATE.	OA	A2
YM	THESE SERVICES ARE EXCLUDED FROM ANY REIMBURSEMENT DETERMINATIONS AS THEY ARE CONSIDERED INCLUDED IN OTHER SERVICES, ARE INSUFFICIENTLY SPECIFIC SERVICES, OR ARE COVERED UNDER A SEPARATE AGREEMENT. THE PATIENT IS NOT RESPONSIBLE FOR THESE CHARGES.	OA	97
YN	SINCE THIS PROCEDURE CODE SHOULD NOT CONTAIN BOTH A PROFESSIONAL AND A TECHNICAL COMPONENT, THERE IS NO ALLOWANCE FOR THE BILLED COMPONENT FOR THIS SERVICE.	OA	A2
YO	THE ORIGINALLY BILLED SERVICE WAS ADJUSTED BASED ON THE NUMBER OF UNITS BILLED. ONLY ONE SERVICE PER DAY IS REASONABLE FOR THIS PROCEDURE. THE CHARGES HAVE BEEN REDUCED BASED ON THE NUMBER OF UNITS BILLED AND BENEFITS ARE BASED ON THE ADJUSTED AMOUNT. NO BENEFITS ARE ALLOWED FOR THIS DUPLICATE PROCEDURE.	PR	57
YP	URN CONTRACTUAL AGREEMENT	CO	A2
YR	THE PROCEDURE CODE MODIFIER SUBMITTED IS NOT APPROPRIATE FOR THE PROVIDER RENDERING SERVICES. PLEASE REVIEW THE PROCEDURE CODE MODIFIER SUBMITTED AND RESUBMIT THE CLAIM WITH THE CORRECT PROCEDURE CODE MODIFIER.	OA	8
YS	WE HAVE REVIEWED THE PROCEDURE CODE MODIFIER REPORTED FOR THIS CLAIM. CLAIM REIMBURSEMENT HAS BEEN ADJUSTED ACCORDINGLY.	CO	4
YT	WE HAVE ASSIGNED THE MOST APPROPRIATE PROCEDURE CODE MODIFIER FOR THIS CLAIM BASED ON OTHER CLAIMS PROCESSED FOR THIS PATIENT. WE HAVE BASED CLAIM REIMBURSEMENT ON THE PROCEDURE CODE MODIFIER ASSIGNED.	CO	4
YU	THIS CHARGE CANNOT BE PAID. THE CLAIM REIMBURSEMENT FOR THE DELIVERY OF ANESTHESIA IS BASED ON ONLY ONE OF THE PROCEDURE CODES SUBMITTED.	PR	96
YV	THIS CHARGE CANNOT BE PAID. THE ANESTHESIA FEE THAT WAS CONSIDERED ON THIS CLAIM INCLUDES ALL SERVICES NORMALLY ASSOCIATED WITH THE DELIVERY OF ANESTHESIA.	PR	96
YW	THE PLAN WILL PAY THE 8.85% SURCHARGE AS REQUIRED BY THE NEW YORK HEALTH CARE REFORM ACT ON BENEFITS PAID AND ANY COPAY APPLIED. THE PATIENT IS RESPONSIBLE FOR PAYING THE 8.85% SURCHARGE ON ANY CHARGES APPLIED TO THE DEDUCTIBLE AND PATIENT COINSURANCE. THESE SURCHARGE AMOUNTS ARE INCLUDED IN THE AMOUNT SHOWN AS "PATIENT RESPONSIBILITY". THE PATIENT IS ALSO RESPONSIBLE FOR THE 8.85% SURCHARGE ON ANY NON-COVERED CHARGES. (FOR DATES OF SERVICE PRIOR TO 07/01/03, 8.18% APPLIES.)	CO	137
YY	NATIONAL IMMUNIZATION PROJECT		
YZ			

United Platform Proprietary Code	United Platform Proprietary Description	ANSI Claim Adjustment Group Code	ANSI Claim Adjustment Reason Code
Y1	THIS SERVICE LINE SUBMITTED WITH MULTIPLE UNITS WILL BE RECODED TO MULTIPLE SERVICE LINES TO SEPARATE THE UNITS.	CO	97
Y2	FOR PROCESSING PURPOSES, THIS SERVICE LINE HAS BEEN WITH A SINGLE UNIT.	CO	97
Y3	NON-NETWORK BENEFITS HAVE BEEN APPLIED SINCE THE SERVICE WAS PERFORMED BY A NON-NETWORK HEALTH CARE PROVIDER.	PR	38
Y4	ACCORDING TO YOUR PLAN, BENEFITS ARE ONLY AVAILABLE AT THE NETWORK LEVEL WHEN A NETWORK HEALTH CARE PROVIDER IS USED. SINCE THIS SERVICE WAS PERFORMED BY A NON-NETWORK HEALTH CARE PROVIDER, NO BENEFITS ARE PAYABLE.	PR	38
Y5	NON-NETWORK BENEFITS HAVE BEEN APPLIED TO THESE LAB AND/OR DIAGNOSTIC SERVICES BECAUSE YOU USED A NON-NETWORK HEALTH CARE PROVIDER.	PR	38
Y8	THIS SERVICE LINE IS BEING RECODED TO ADJUST THE ANESTHESIA MINUTES.	CO	B15
Y9	THE NOT COVERED AMOUNT REPRESENTS THE AMOUNT PAID BY YOUR BASE PLAN.	PR	23
ZA			
ZB			
ZC		CO	119
ZD			
ZE	WE HAVE RECONSIDERED THESE CHARGES.		
ZF			
ZG			
ZH			
ZI			
ZJ			
ZK			
ZL			
ZM			
ZN			
ZO			
ZP	WE HAVE RECONSIDERED THESE CHARGES AND MADE THIS PAYMENT BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
ZQ	THE IRS REQUIRES US TO WITHHOLD PERCENTAGE OF BENEFITS PAID TO THE ABOVE TAXPAYER NAME AND ID NUMBER. THIS AMOUNT HAS BEEN SENT TO THE IRS AS PREPAID FEDERAL TAXES. THE PATIENT IS NOT RESPONSIBLE FOR THIS PAYMENT. IF YOU HAVE QUESTIONS, CALL (814)534-2399.	PR	105
ZR	YOU WILL RECEIVE A SEPARATE EXPLANATION OF BENEFITS DESCRIBING YOUR EXECUTIVE PLAN COVERAGE.	OA	96
ZS	WE HAVE RECONSIDERED THESE CHARGES.		
ZT			
ZU			
ZV			
ZW			
ZX			
ZY			
ZZ			
Z0			
Z1			
Z2			
Z3			
Z4			
Z5			
Z6			
Z9		OA	96
0A	HMN/RAN/AMN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0B	PRIMARY HEALTH SERVICES IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0C	HEALTH PAYORS ORGANIZATION/FPN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2

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0D	GALAXY HEALTH NETWORK/NPN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0E	PPONEXT/PHN/HEATHSTAR IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0F	PREFERRED HEALTH NETWORK IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0G	NOVANET/SPECIAL NET IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0H	FORTIFIED PROVIDER NETWORK IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0I	INTERWEST TRADITIONAL IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0J	HFN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0K	INTERPLAN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0L	PREFERRED CARE IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0M	MANAGED CARE STRATEGIES IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0N	MEDICAL RESOURCE/NATIONAL PROVIDER NETWORK IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT PLEASE CALL COALITION AMERICA, INC. AT F1-888-346-8488 FOR ASSISTANCE.	CO	A2
0O	PROVIDER SELECT IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0P	BEECH STREET IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0Q	TRPN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT	CO	A2

United Platform Proprietary Code	United Platform Proprietary Description	ANSI Claim Adjustment Group Code	ANSI Claim Adjustment Reason Code
0R	ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE. INDEPENDENT MEDICAL SYSTEMS IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0S	AMERICAN PPO IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0T	INTERGROUP IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0U	STATEWIDE PPO IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0V	MEDICAL RESOURCES IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0W	MULTIPLAN IS THE NETWORK FOR WHICH THE DISCOUNT WAS TAKEN ON THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THE DISCOUNT, WHICH IS THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU HAVE ANY QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488 FOR ASSISTANCE.	CO	A2
0X	THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED REPRESENTS A DISCOUNT BASED ON NEGOTIATIONS BY COALITION AMERICA, INC. FOR THIS CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT. IF YOU HAVE QUESTIONS ON THE DISCOUNTED AMOUNT, PLEASE CALL COALITION AMERICA, INC. AT 1-888-346-8488.	CO	A2
0Y			
01	YOU HAVE REACHED THE MAXIMUM PREGNANCY BENEFIT ALLOWED BY YOUR PLAN.	PR	119
02	YOUR MAJOR MEDICAL DEDUCTIBLE HAS NOT BEEN REACHED FOR THE CALENDAR YEAR.	PR	1
03	MEDICARE HAS PAID THE SAME AS OR MORE THAN YOUR PLAN WOULD PAY THEREFORE, NO PAYMENT WILL BE MADE BY YOUR PLAN.	PR	23
04	THIS FACILITY DOES NOT MEET YOUR PLAN'S DEFINITION OF A 'HOSPITAL'.	PR	58
05	OUR RECORDS SHOW WE HAVE ALREADY PROCESSED THIS CHARGE.	CO	18
06	THESE CHARGES ARE FOR SERVICES RECEIVED BEFORE THE EFFECTIVE DATE OF THIS PATIENT'S COVERAGE. THEREFORE, BENEFITS ARE NOT AVAILABLE.	PR	26
07	THESE CHARGES ARE FOR SERVICES PROVIDED AFTER THIS PATIENT'S COVERAGE WAS CANCELED, THEREFORE, THEY ARE NOT COVERED.	PR	27
08	ACCORDING TO OUR RECORDS, THIS DEPENDENT IS NOT LISTED AS COVERED UNDER YOUR PLAN. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. PLEASE CHECK WITH YOUR EMPLOYER'S BENEFITS DEPARTMENT ON ENROLLMENT STATUS OF THIS DEPENDENT.	OA	32
09	PLEASE SEND A COPY OF THIS EXPLANATION OF BENEFITS AND A COPY OF THE BILL TO YOUR MEDICARE CARRIER. MEDICARE MAY BE REQUIRED TO PAY MORE FOR THESE EXPENSES.	OA	
1A	ACCORDING TO YOUR PLAN, CLAIMS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES NOT PROVIDED IN THE HOSPITAL OR PHYSICIAN'S OFFICE MUST BE SUBMITTED TO NORTHWOOD/NPN P.O. BOX 3078, CENTERLINE, MI 48015-0078. IF YOU HAVE ANY QUESTIONS, PLEASE CALL 1 (800) 936-9314.	CO	109
1B	BENEFITS WERE REDUCED BECAUSE THE PROVIDER DID NOT NOTIFY US OF THE SERVICES (PRIOR TO THE INITIAL TREATMENT OR VISIT.) YOU ARE NOT RESPONSIBLE FOR THE EXCLUDED CHARGE. A NOTIFICATION NEEDS TO BE OBTAINED FOR FUTURE TREATMENTS OR VISITS. TO NOTIFY US PLEASE CALL THE MENTAL HEALTH ADMINISTRATOR IN YOUR AREA. SEE THE BACK OF YOUR MEDICAL ID CARD FOR THE PHONE NUMBER.	PR	62

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1C	YOUR INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT ALLOWS ONE INPATIENT CHARGE PER DAY BY THE ATTENDING DOCTOR.	OA	122
1D	NETWORK BENEFITS WERE ALLOWED ON THIS CLAIM DUE TO AN EMERGENCY. SUBSEQUENT RELATED EXPENSES WILL BE PAID AT AN OUT-OF-NETWORK BENEFIT LEVEL IF WE DO NOT RECEIVE NOTIFICATION.	CO	62
1E	YOUR BENEFITS HAVE BEEN REDUCED TO COVER THE DAYS INDICATED DURING THE NOTIFICATION PROCESS.	PR	62
1F	THIS CHARGE SHOULD HAVE BEEN PENALIZED SINCE WE DID NOT RECEIVE A NOTIFICATION. HOWEVER, SINCE YOUR DEDUCTIBLE HAS NOT BEEN MET, THE FULL AMOUNT OF THE ALLOWABLE EXPENSE WAS APPLIED TO YOUR DEDUCTIBLE.	CO	1
1G	PRIOR NOTIFICATION NEEDS TO BE RECEIVED BY THE MENTAL HEALTH ADMINISTRATOR IN YOUR AREA FOR SERVICES RENDERED BY A SOCIAL WORKER OR NON LICENSED PSYCHOLOGIST. IF NOTIFICATION IS NOT RECEIVED THESE SERVICES WILL NOT BE COVERED UNDER YOUR PLAN.	OA	62
1I	THE NUMBER OF TREATMENTS OR VISITS EXCEEDS THE PLAN MAXIMUM OF 30 VISITS PER CALENDAR YEAR. THIS HAS RESULTED IN A DENIAL OF BENEFITS. CONTINUATION OF TREATMENT WILL REQUIRE A REVIEW TO DETERMINE COVERAGE. CALL THE MENTAL HEALTH ADMINISTRATOR IN YOUR AREA.	PR	119
1J	TREATMENT BY OUT OF NETWORK SOCIAL WORKERS, NON LICENSED PSYCHOLOGISTS, PSYCHIATRISTS OR ADDICTION COUNSELORS, DO NOT QUALIFY AS COVERED PROVIDERS WHEN CLAIMS ARE SUBMITTED FOR SECONDARY REIMBURSEMENT.	PR	38
1K	THIS NON-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT ON YOUR BILL. YOU ARE ONLY RESPONSIBLE FOR PAYING THE "PATIENT PAYS" AMOUNT WHICH INCLUDES THE COPAY REQUIRED FOR USING A NON-NETWORK FACILITY.	CO	A2
1L	THIS NON-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT ON YOUR BILL. YOU ARE ONLY RESPONSIBLE FOR PAYING THE "PATIENT PAYS" AMOUNT.	CO	A2
1M	ON JAN. 1, 1999, VALUE OPTIONS AND GROUP HEALTH INCORPORATED TOOK OVER THE RESPONSIBILITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE CLAIMS. PLEASE HAVE THE MENTAL HEALTH OR SUBSTANCE ABUSE PROVIDER SEND AN ITEMIZED BILL FOR THIS CLAIM AND FUTURE MENTAL HEALTH OR SUBSTANCE ABUSE CLAIMS WITH DATES OF SERVICE AFTER JAN. 1, 1999, TO VALUE OPTIONS, P.O. BOX 778, TROY, NEW YORK 12181-0788.	PR	109
1N	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER, BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE IN ACCORDANCE WITH HIS OR HER MULTIPLAN/HEALTH INFO NET AGREEMENT. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.	CO	A1
1O	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR REPAIR OR REPLACEMENT OF PROSTHETIC OR DURABLE MEDICAL EQUIPMENT EXCEPT IF THERE IS A CHANGE IN MEDICAL CONDITION OR TO IMPROVE PHYSICAL FUNCTION.	PR	96
1P	MEDICARE PART B COINSURANCE IS NOT A COVERED EXPENSE FOR THIS TYPE OF SERVICE UNDER YOUR MEDICARE SUPPLEMENT PLAN.	PR	96
1Q	THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A UNITED HEALTHCARE PROVIDER BUT HAS ACCEPTED A DISCOUNT ON THIS SERVICE AS PART OF THE SHARED SAVINGS PROGRAM AND IN ACCORDANCE WITH HIS OR HER TRPN/MCS AGREEMENT. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE 'PATIENT PAYS' COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROVIDER FOR A REFUND.	CO	A1
1S	ACCORDING TO OUR RECORDS, THIS DEPENDENT IS NOT LISTED AS COVERED UNDER YOUR PLAN PLEASE CONTACT FEDERAL EXPRESS ENROLLMENTS AT 1-800-525-4478.	OA	32
1T	WE ARE UNABLE TO PROCESS THIS CLAIM AT THIS TIME SINCE NO PREAUTHORIZATION OF BENEFITS IS ON FILE. PLEASE CALL HEALTHCARE REVIEW	PR	62
1U	PEOPLEHELP MUST BE NOTIFIED OF ANY TREATMENT FOR A MENTAL HEALTH/ SUBSTANCE ABUSE DIAGNOSIS FOR FURTHER BENEFITS TO BE PAID. CALL 1-800-274-HELP TO NOTIFY PEOPLEHELP. PAYMENT WILL NOT BE MADE FOR ANY ADDITIONAL SERVICES THAT HAVE NOT BEEN NOTIFIED.	PR	62
1V	THE EVALUATION AND MANAGEMENT CODE SHOWN ON THIS CLAIM WAS BILLED AT A HIGHER LEVEL THAN INDICATED IN THE NOTIFICATION RESPONSE SENT TO	CO	42

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1W	THE HEALTH CARE PROVIDER BY ACN GROUP. PAYMENT WAS MADE AT THE INDICATED LEVEL. THE BILLING ADJUSTMENT IS BASED ON NEGOTIATIONS WITH YOUR HEALTH CARE FACILITY. THE PATIENT IS NOT RESPONSIBLE FOR THE BILLING ADJUSTMENT.	CO	A2
1X	ALL FUTURE THERAPY SERVICES WILL BE SUBJECT TO ADDITIONAL REVIEW TO DETERMINE BENEFIT COVERAGE.	OA	133
1Y	THESE EXPENSES MUST BE SUBMITTED TO YOUR EMPLOYEE ASSISTANCE PROGRAM REPRESENTATIVE IN ORDER TO BE ELIGIBLE FOR CONSIDERATION UNDER YOUR PLAN.	PR	109
1Z	THE EXCLUDED CHARGES EXCEED THOSE INDICATED IN THE NOTIFICATION PROCESS HAVE ANY QUESTIONS, PLEASE CALL HEALTH INTERNATIONAL AT 1-800-638-9599.	PR	62
10	COVERAGE FOR A RESIGNED EMPLOYEE ENDS ON THE TERMINATION DATE. WHEN YOU RECEIVED THESE SERVICES, YOU WERE RESIGNED NO BENEFITS ARE AVAILABLE.	OA	27
11	ROUTINE EYE EXAMS ARE NOT COVERED BY YOUR PLAN.	PR	49
12	WE HAVE SPLIT THE PAYMENT FOR THESE SERVICES.	CO	42
13	YOUR PLAN DOES NOT COVER THIS NON-MEDICAL SERVICE OR PERSONAL ITEM.	PR	96
14	YOUR PLAN ONLY COVERS EXPENSES FOR THE TREATMENT OF AN INJURY OR ILLNESS.	PR	167
15	SERVICES YOU RECEIVED FROM THIS PROVIDER ARE NOT COVERED BY YOUR PLAN.	OA	52
16	HOUSEHOLD OR CONVENIENCE ITEMS ARE NOT COVERED BY YOUR PLAN.	PR	96
17	YOUR PLAN DOES NOT COVER THIS DENTAL EXPENSE.	PR	96
18	THE DIFFERENCE BETWEEN A SEMI-PRIVATE AND A PRIVATE ROOM RATE IS NOT COVERED BY YOUR PLAN.	PR	96
19	ACCORDING TO YOUR PLAN, THIS PREVENTATIVE PHYSICAL EXAMINATION OR RELATED TEST IS NOT COVERED.	OA	49
2A	THESE SERVICES EXCEED THE SERVICES PREVIOUSLY INDICATED IN THE NOTIFICATION PROCESS. NO ADDITIONAL BENEFITS ARE AVAILABLE.	CO	62
2B	THIS CLAIM HAS BEEN REFERRED TO MANAGED PHYSICAL NETWORK, INC. FOR REVIEW. ADDITIONAL INFORMATION MAY BE REQUESTED FROM YOUR PROVIDER OF SERVICE. YOU WILL BE NOTIFIED ONCE A DETERMINATION HAS BEEN MADE.	CO	109
2D	MANAGED PHYSICAL NETWORK WAS NOT NOTIFIED OF THIS CARE. THE MEMBER IS NOT RESPONSIBLE FOR THIS CHARGE. IF YOU HAVE ANY QUESTIONS CONCERNING THIS DETERMINATION, PLEASE CALL, TOLL FREE, 1-877-7NYSHIP (1-877-769-7447).	CO	62
2F	PAYMENT IS LOWER BECAUSE THE CLAIM WAS PROCESSED AS DESCRIBED IN THE NOTIFICATION PROCESS. THE MEMBER IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PROVIDER AND THE COVERED AMOUNT.	CO	62
2G	PLEASE HAVE THE PROVIDER SUBMIT THIS CLAIM TO THE MANAGED PHYSICAL NETWORK FOR REVIEW AND/OR AUTHORIZATION.	CO	109
2H	NO BENEFITS ARE PAYABLE BASED ON THE PROCEDURE CODE BILLED. PLEASE HAVE THE PROVIDER SUBMIT A DETAILED DESCRIPTION OF THIS SERVICE TO MANAGED PHYSICAL NETWORK, INC. P.O. BOX 8200, KINGSTON, NY 12402.	OA	17
2I	THESE CHARGES APPEAR TO BE THE RESPONSIBILITY OF THE PATIENT'S NO-FAULT CARRIER. IF THESE CHARGES ARE NOT PAID BY THE NO-FAULT CARRIER, PLEASE SEND A COPY OF THEIR DENIAL LETTER TO MANAGED PHYSICAL NETWORK, INC., P.O. BOX 8200, KINGSTON, NY 12402 FOR FURTHER REVIEW.	PR	21
2J	THIS CHARGE WAS PROCESSED BASED ON THE PROCEDURE DESCRIBED IN THE NOTIFICATION PROCESS WITH MANAGED PHYSICAL NETWORK, INC. IF YOU HAVE ANY QUESTIONS CONCERNING THIS DETERMINATION, PLEASE CALL, TOLL FREE, 1-877-7NYSHIP (1-877-769-7447.)	CO	62
2K	MANAGED PHYSICAL NETWORK DID NOT RECEIVE NOTIFICATION FOR THESE CHARGES. THE PROVIDER IS RESPONSIBLE FOR NOTIFYING MANAGED PHYSICAL NETWORK, INC. BEFORE THE FILING DEADLINE.	PR	62
2L	YOUR CLAIM FOR THIS SERVICE HAS BEEN DENIED BECAUSE IT WAS RECEIVED AFTER THE FILING DEADLINE. THE PROVIDER IS RESPONSIBLE FOR FILING A CLAIM WITH MANAGED PHYSICAL NETWORK INC. WITHIN 30 DAYS OF RECEIVING A DETERMINATION OF BENEFITS FROM THE PRIMARY PAYER. THE MEMBER IS NOT RESPONSIBLE FOR THIS AMOUNT.	OA	29
2M	ADDITIONAL INFORMATION IS NEEDED FROM THE PROVIDER OF SERVICE BEFORE MANAGED PHYSICAL NETWORK, INC. CAN REVIEW THIS CLAIM.	OA	16

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2N	THE INFORMATION HAS BEEN REQUESTED FROM THE PROVIDER. THE CLAIM WILL BE CONSIDERED WHEN THE INFORMATION IS RECEIVED. THIS CLAIM HAS BEEN PROCESSED BASED ON AN AGREEMENT BETWEEN MANAGED PHYSICAL NETWORK, INC. AND THE PROVIDER OF SERVICE. IF YOU HAVE ANY QUESTIONS CONCERNING THIS DETERMINATION, PLEASE CALL 1-866-333-4866.	CO	A2
2O	THE PHYSICIAN OR PROVIDER AGREED TO ACCEPT THIS AMOUNT. YOU ARE RESPONSIBLE FOR ANY APPLICABLE COPAYMENT, DEDUCTIBLE, OR COINSURANCE AMOUNT.	CO	A2
2P	YOUR CLAIM HAS BEEN DENIED BECAUSE IT WAS RECEIVED AFTER THE FILING DEADLINE. CLAIMS MUST BE RECEIVED BY MANAGED PHYSICAL NETWORK, INC. WITHIN 90 DAYS OF THE DATE OF SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THIS AMOUNT.	OA	29
2Q	YOUR CLAIM HAS BEEN DENIED BECAUSE IT WAS RECEIVED AFTER THE MANAGED PHYSICAL NETWORK, INC. FILING DEADLINE FOR RESUBMISSIONS. ALL RESUBMISSIONS MUST OCCUR WITHIN 30 DAYS OF RECEIPT OF THE EXPLANATION OF BENEFITS. THE MEMBER IS NOT RESPONSIBLE FOR THIS AMOUNT.	OA	29
2R	A WORK RELATED INJURY OR ILLNESS IS NOT COVERED UNDER YOUR MEDICAL PLAN. PLEASE SEND THESE EXPENSES TO YOUR WORKERS' COMPENSATION CARRIER. IF THESE CHARGES ARE NOT COVERED BY WORKERS' COMPENSATION, PLEASE SEND A COPY OF THEIR DENIAL LETTER TO MANAGED PHYSICAL NETWORK, INC., P.O. BOX 8200, KINGSTON, NY 12402 FOR FURTHER REVIEW.	OA	109
2S	MANAGED PHYSICAL NETWORK INC., HAS REVIEWED THE SUBMITTED INFORMATION CONCERNING THE SERVICES PROVIDED. BASED ON THIS REVIEW, NO BENEFITS ARE AVAILABLE. AN EXPLANATION WAS PREVIOUSLY SENT TO YOU AND TO YOUR PROVIDER. IF YOU HAVE ANY QUESTIONS CONCERNING THIS DETERMINATION, PLEASE CALL, TOLL FREE, 1-877-7NYSHIP (1-877-769-7447).	PR	96
2T	NO SEPARATE BENEFIT IS DUE FOR THIS SERVICE OR ITEM BECAUSE IT IS INCLUDED IN THE ALLOWANCE FOR OTHER SERVICES PERFORMED ON THE SAME DAY. IF YOU HAVE ANY QUESTIONS CONCERNING THIS DETERMINATION, PLEASE CALL THE TOLL-FREE NUMBER 1-877-7NYSHIP (1-877-769-7447.)	CO	62
2V	BASED ON THE AGREEMENT BETWEEN NEW YORK STATE INSURANCE DEPARTMENT AND UNITEDHEALTHCARE, WE HAVE REVIEWED THE ADDITIONAL INFORMATION SUBMITTED AND HAVE RECONSIDERED THESE CHARGES.		
2W	IN ACCORDANCE WITH TEXAS LAW, PAYMENT IS BASED ON BILLED CHARGES.	OA	96
2X	BENEFITS WERE BASED ON THE TOTAL NUMBER OF SERVICES DESCRIBED IN THE NOTIFICATION PROCESS WITH MANAGED PHYSICAL NETWORK, INC. IF YOU HAVE ANY QUESTIONS CONCERNING THIS DETERMINATION, PLEASE CALL, TOLL FREE, 1-877-7NYSHIP (1-877-769-7447.)	CO	62
2Y	SINCE MEDICARE PAYS 100% OF THEIR APPROVED AMOUNT FOR THIS CHARGE, NO ADDITIONAL BENEFITS ARE PAYABLE TO THE PROVIDER.	PR	23
2Z	FOR FURTHER CONSIDERATION, THE PROVIDER MUST SEND US THE COMPLETE EXPLANATION OF MEDICARE BENEFITS (EOMB) SHOWING THE REASON WHY MEDICARE DECLINED THIS CHARGE.	OA	16
20	BASED ON THE CONTRACTUAL AGREEMENT THE PHYSICIAN OR MEDICAL PROVIDER HAS WITH UNITEDHEALTHCARE, EXPENSES FOR PREPARING CLAIM FORMS OR COPYING MEDICAL RECORDS ARE NOT REIMBURSABLE FEES. IF THESE RECORDS WERE SUPPLIED BY A COPY VENDOR, THEN THE EXPENSES FOR THIS SERVICE SHOULD BE REFERRED TO THE PHYSICIAN OR OTHER MEDICAL PROVIDER WHO REQUESTED THE COPY SERVICES.	PR	96
21	THE CHARGES ON YOUR CLAIM WILL BE PROCESSED SEPARATELY. ALL OF THE CHARGES WILL BE PROCESSED AS QUICKLY AS POSSIBLE.	OA	133
22	WE HAVE RECEIVED MORE INFORMATION AND RECONSIDERED THESE CHARGES.		
23	WE PROCESSED THESE CHARGES AFTER ESTIMATING YOUR OTHER INSURANCE PLAN'S COVERAGE. IF OUR ESTIMATE IS WRONG, PLEASE SEND US A PROOF OF PAYMENT FROM YOUR OTHER PLAN AND WE WILL REPROCESS YOUR CLAIM.	PR	23
24	YOUR PLAN DOES NOT COVER THIS EXPENSE.	PR	96
25	YOUR PLAN DOES NOT COVER THIS VISION SERVICE OR EYE REFRACTION EXPENSE.	PR	96
26	YOUR PLAN DOES NOT COVER EXPENSES FOR THIS IMMUNIZATION.	PR	96
27	THESE CHARGES HAVE BEEN PROCESSED UNDER YOUR EXECUTIVE PLAN AFTER TAKING INTO CONSIDERATION THE BENEFITS ALREADY PAID BY YOUR OTHER BENEFIT PLAN.	PR	23
28	THIS PATIENT IS COVERED UNDER TWO SEPARATE BENEFIT PLANS. ANY REMAINING BALANCE WILL BE CONSIDERED UNDER THE OTHER PLAN AND SHOWN ON A SEPARATE EXPLANATION OF BENEFITS.	PR	22

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29	YOUR PLAN COVERS REASONABLE CHARGES FOR COVERED HEALTH SERVICES. THE REASONABLE CHARGE IS BASED ON AMOUNTS CHARGED BY OTHER PHYSICIANS OR HEALTH CARE PROFESSIONALS IN THE AREA FOR SIMILAR SERVICES OR SUPPLIES. BENEFITS ARE NOT AVAILABLE FOR THAT PORTION OF THE CHARGE THAT EXCEEDS THE REASONABLE CHARGE DETERMINED FOR THIS SERVICE.	CO	42
3A	THIS SERVICE IS NOT COVERED FOR THE DIAGNOSIS LISTED ON THE CLAIM.	OA	167
3B	THE INITIAL EXAM IS A COVERED EXPENSE. HOWEVER, THE TREATMENT FOR THIS CONDITION IS NOT COVERED UNDER YOUR MEDICAL BENEFITS PLAN.	PR	96
3C	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR COMPANION SERVICES DURING TRANSPORTATION.	PR	96
3D	PLEASE SEND MEDICARE THE INFORMATION THEY HAVE REQUESTED. RESUBMIT THE CORRECTED MEDICARE STATEMENT TO US FOR FURTHER PROCESSING.	OA	16
3E	PLEASE CONTACT YOUR HEALTH BENEFITS ADMINISTRATOR TO ADD YOUR NEWBORN AS A COVERED DEPENDENT. ONCE YOUR NEWBORN HAS BEEN SUCCESSFULLY ADDED, PLEASE RETURN THIS STATEMENT TO OUR OFFICE TO EXPEDITE THE PROCESSING OF THIS CLAIM.	PR	31
3F	RATE DIFFERENTIALS, SUCH AS AN ADDITIONAL CHARGE FOR OVERTIME, NIGHT TIME HOURS OR HOLIDAY HOURS, ARE NOT COVERED.	PR	96
3G	THIS REIMBURSEMENT IS BASED ON A SPECIAL AGREEMENT WITH THIS PROVIDER. IT IS NOT SUBJECT TO ANY PROVISIONS OF YOUR MEDICAL PLAN AND IS NOT APPLIED TO ANY MAXIMUMS. THANK YOU FOR USING A MANAGED CARE NETWORK PROVIDER.	OA	A2
3H	CHARGES RELATED TO THIS DIAGNOSIS ARE NOT COVERED UNDER YOUR MEDICAL BENEFITS PLAN.	PR	96
3I	BEFORE WE CAN DETERMINE ANY AVAILABLE BENEFITS, THE LABORATORY MUST SEND US A COPY OF THE REFERRING PHYSICIAN'S ORDERS AND DIAGNOSIS TO DETERMINE BENEFIT COVERAGE FOR THIS CHARGE.	OA	16
3J	YOUR PLAN DOES NOT COVER DOMICILIARY CARE RESPITE CARE	PR	96
3K	ACCORDING TO OUR RECORDS, THIS AMOUNT HAS PREVIOUSLY BEEN CONSIDERED AS PRENATAL CARE VISITS. THEREFORE, SINCE PRENATAL CARE VISITS ARE CONSIDERED PART OF THE TOTAL ALLOWABLE GLOBAL DELIVERY FEE, THE AMOUNT ALREADY PAID IS BEING DEDUCTED FROM THE TOTAL ALLOWABLE DELIVERY FEE.	PR	B15
3L	THIS AMOUNT EXCEEDS THE SCHEDULE ALLOWANCE FOR TOTAL OBSTETRICAL CARE.	PR	96
3M	THIS SERVICE WAS NOT PROVIDED WITHIN THE TIMEFRAME INDICATED DURING THE NOTIFICATION PROCESS, THEREFORE BENEFITS HAVE BEEN DENIED. PLEASE CALL, TOLL FREE, 1-877-7NYSHIP (1-877-769-7447) OR FAX 1-845-382-7996 IF YOU HAVE ANY QUESTIONS.	OA	62
3N	HCAP COVERED SERVICES RECEIVED FROM A NON-NETWORK PROVIDER ARE REIMBURSED AT 50% OF THE NETWORK ALLOWANCE. IF FUTURE SERVICES ARE REQUIRED, CALL HCAP, TOLL FREE, AT 1-877-7NYSHIP (1-877-769-7447) FOR INFORMATION REGARDING PAID-IN-FULL BENEFITS.	PR	38
3O	IF THE SURGERY WAS PERFORMED ON A HOSPITAL INPATIENT BASIS OR IN THE EMERGENCY ROOM, THE BENEFIT FOR THIS CHARGE IS INCLUDED IN BLUE CROSS' PAYMENT TO THE HOSPITAL. IF PERFORMED ELSEWHERE, PLEASE SUBMIT THE SURGEON'S BILL.	OA	16
3P	BENEFITS FOR THIS SERVICE HAVE BEEN INCLUDED IN THE ALLOWANCE(S) FOR OTHER SERVICES PERFORMED ON THE SAME DAY. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE HOME CARE ADVOCACY PROGRAM, TOLL FREE, AT 1-877-7NYSHIP (1-877-769-7447).	PR	97
3Q	THIS PLAN COVERS SERVICES AND SUPPLIES BASED ON THE AREA'S MEDICARE FEE SCHEDULE. THE ALLOWABLE CHARGE IS THE AMOUNT MEDICARE CHARGES FOR SERVICES AND SUPPLIES. BENEFITS ARE NOT AVAILABLE FOR THAT PORTION OF THE MEDICARE CHARGE THAT EXCEEDS THE AREA'S MEDICARE ALLOWABLE AMOUNT DETERMINED FOR THIS SERVICE. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	OA	42
3R	ACCORDING TO YOUR PLAN, SERVICES FOR HOME CARE SHOULD BE ARRANGED THROUGH THE HOME CARE ADVOCACY PROGRAM (HCAP). IF HCAP IS NOT USED, A PENALTY IS ASSESSED TO YOU. CONTACT HCAP, TOLL FREE, AT 1-877-7NYSHIP (1-877-769-7447) TO ARRANGE FUTURE CARE AND AVOID BEING ASSESSED A PENALTY.	PR	96
3S	BENEFITS FOR PHARMACEUTICAL PRODUCTS ARE BASED ON THE AVERAGE WHOLESALE PRICE (AWP). IF YOU DISAGREE WITH THIS DETERMINATION,	PR	96

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3T	PLEASE HAVE THE PHYSICIAN OR PROVIDER SUBMIT DOCUMENTATION SHOWING THAT HIS/HER ACTUAL COSTS WERE ABOVE THE AWP. OUR RECORDS SHOW THAT WE ALREADY PROCESSED AN IDENTICAL PROCEDURE FOR THIS DATE OF SERVICE. THE ONLY CHANGE WE SEE IS A DIFFERENT BILLED AMOUNT. SINCE WE HAVE NOT RECEIVED ANY SUPPORTING DOCUMENTATION FOR RECONSIDERATION, NO BENEFITS ARE BEING ALLOWED.	CO	18
3U	THIS CLAIM HAS BEEN REFERRED TO OUR CONSULTANT. ADDITIONAL INFORMATION MAY BE REQUESTED FOR FURTHER REVIEW. YOU WILL BE NOTIFIED ONCE A DETERMINATION HAS BEEN MADE.	OA	133
3V	BENEFITS FOR THIS SERVICE ARE INCLUDED IN THE HOSPITAL'S REIMBURSEMENT FROM BLUE CROSS. THE PROVIDER OF SERVICE MUST CONTACT THE HOSPITAL FOR PAYMENT OF THIS FEE.	CO	22
3W	OUR RECORDS SHOW THAT THE PHYSICIAN OR OTHER HEALTH CARE PROVIDER DID NOT FULFILL THE PRIOR NOTIFICATION REQUIREMENT OF THE HOME CARE ADVOCACY PROGRAM. THEREFORE, NO BENEFITS ARE DUE FOR THIS SERVICE/ ITEM. THE PATIENT IS NOT RESPONSIBLE FOR THE DENIED AMOUNT(S) AND SHOULD NOT BE BILLED. IF YOU DISAGREE WITH THIS DECISION, PLEASE CALL HCAP AT 1-877-7NYSHIP(1-877-769-7447).	CO	62
3X	YOU HAVE RECEIVED NON-NETWORK BENEFITS. FUTURE BENEFITS FOR CHIROPRACTIC, OCCUPATIONAL AND PHYSICAL THERAPY SERVICES MAY BE AVAILABLE TO YOU AT A LOWER OUT-OF-POCKET EXPENSE IF YOU UTILIZE A NETWORK PROVIDER. IF YOU WISH TO OBTAIN INFORMATION ABOUT NETWORK PROVIDERS IN YOUR AREA, PLEASE CALL, TOLL FREE, 1-877-7NYSHIP (1-877-769-7447.)	OA	38
3Y	THIS FACILITY IS NOT A NETWORK PROVIDER TO A REDUCTION IN CHARGES ON THIS OUTPATIENT CLAIM THROUGH AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND	CO	131
3Z	THIS FACILITY IS NOT A NETWORK PROVIDER TO A REDUCTION IN CHARGES ON THIS INPATIENT CLAIM THROUGH CONCENTRA PREFERRED SYSTEMS. YOU ARE ONLY RESPONSIBLE FOR THE AMOUNT IN THE "PATIENT PAYS" COLUMN OF THIS STATEMENT. YOU ARE NOT	CO	131
30	THIS PAYMENT IS A REPLACEMENT OF A PREVIOUSLY ISSUED CHECK. THE ORIGINAL CHECK HAS A STOP PAYMENT AGAINST IT. THE ORIGINAL CHECK SHOULD NOT BE CASHED.		
31	PREVIOUSLY YOU WERE ADVISED THAT AN OVERPAYMENT WAS MADE ON A PRIOR CLAIM. WE HAVE DEDUCTED THAT OVERPAYMENT FROM THE BENEFITS NOW PAYABLE AND THE BALANCE IS ATTACHED.	OA	88
32	BENEFITS FROM THIS CLAIM WERE REDUCED BY AN OVERPAYMENT FROM A PRIOR CLAIM.	OA	88
33			
34	THIS PLAN UNDER POLICY GA23111 PROVIDES BASIC BENEFITS ONLY.	PR	96
35	THE AMOUNT NOT COVERED IS THE TOTAL OF ANY PROVIDER DISCOUNT APPLIED PLUS THE AMOUNT PAID UNDER YOUR GA-46000 POLICY.	CO	A2
36	REMINDER: PLEASE BE SURE TO INCLUDE YOUR POLICY NUMBER AND SOCIAL SECURITY NUMBER ON ANY BILLS OR CORRESPONDENCE SUBMITTED TO US.	PR	16
37			
38	THIS BILL APPEARS TO BE ELIGIBLE FOR COVERAGE UNDER YOUR PLAN WITH BLUE CROSS. A COPY OF THIS BILL HAS BEEN FORWARDED TO THEM FOR PROCESSING.	PR	22
39	WE WILL NEED A COPY OF THE MEDICARE SUMMARY NOTICE BEFORE YOUR CLAIM CAN BE PROCESSED.	OA	16
4B	ANY AMOUNTS SHOWN AS NOT COVERED REPRESENT THE AMOUNT NOT ALLOWED BY MEDICARE	PR	96
4C	REMAINING BALANCE REPRESENTS YOUR MEDICARE PART B DEDUCTIBLE. THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT	OA	22

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	MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.		
4D	THIS AMOUNT REPRESENTS YOUR MEDICARE PART A DEDUCTIBLE. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	PR	1
4E	YOUR BENEFITS HAVE INCREASED TO A HIGHER COINSURANCE LEVEL.	PR	2
4F	YOU ARE RESPONSIBLE FOR COPAYMENT AND COINSURANCE AMOUNTS. THEREFORE, BENEFITS ARE NOT AVAILABLE.	PR	2
4G	MANAGED HEALTH NETWORK HAS NOT RECEIVED THE REQUIRED NOTIFICATION. THEREFORE, NO BENEFITS ARE PAYABLE.	CO	62
4H	ACCORDING TO YOUR PLAN, MEDICATIONS AND DIAGNOSTIC OR THERAPEUTIC INJECTIONS ARE NOT COVERED.	PR	96
4I	THIS CLAIM MUST BE SENT DIRECTLY TO AMERICAN SPECIALTY HEALTH NETWORK (ASHN), PO BOX 509002, SAN DIEGO, CA, 92510 FOR CONSIDERATION.	CO	109
4J	YOUR PLAN DOES NOT PROVIDE REIMBURSEMENT FOR MEDICARE PART B DEDUCTIBLE.	PR	96
4K	THIS AMOUNT REPRESENTS THE BENEFITS PAYABLE FOR YOUR MEDICARE COINSURANCE DAYS. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	OA	2
4L	THIS AMOUNT REPRESENTS THE BENEFITS PAYABLE FOR YOUR MEDICARE LIFETIME RESERVE DAYS. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	OA	96
4M	THIS AMOUNT REPRESENTS THE BENEFITS PAYABLE FOR YOUR MEDICARE EXTENDED CARE FACILITY DAYS. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	CO	22
4N	YOUR PLAN DOES NOT REIMBURSE THE MEDICARE DEDUCTIBLE FOR BLOOD.	PR	66
4O	THIS SERVICE IS NOT COVERED UNDER THE WELLNESS PROGRAM.	PR	96
4P	WE MUST VERIFY YOUR CURRENT PREMIUM STATUS. PLEASE ALLOW FOUR TO SIX WEEKS FOR YOUR CLAIM TO BE REPROCESSED.	PR	16
4Q	OUR SYSTEM DOES NOT CURRENTLY CONTAIN A LISTING FOR THIS PROVIDER. YOUR CLAIM WILL BE CONSIDERED AS SOON AS OUR DATABASE IS UPDATED.	PR	16
4R	IN ORDER TO DETERMINE THE CORRECT CONTRACTED RATE FOR THE BILLED REVENUE CODE, A COPY OF THE MANUFACTURER'S INVOICE MUST BE PROVIDED.	OA	16
4S	ACCORDING TO YOUR PLAN, BALANCES INCURRED DUE TO A FAILURE TO COMPLY WITH THE PROVISIONS OF YOUR PRIMARY PLAN, ARE NOT COVERED.	PR	136
4T	ACCORDING TO YOUR PLAN, YOU MUST ENROLL YOUR CHILDREN WITHIN 30 DAYS OF BIRTH. FAILURE TO ENROLL THEM WILL AFFECT FUTURE CLAIM PROCESSING. PLEASE CONTACT YOUR BENEFITS DEPARTMENT.	OA	16
4U	WE ARE REVIEWING THIS EXPENSE. WE THANK YOU FOR YOUR PATIENCE AND WILL LET YOU KNOW OUR DECISION.	OA	133
4V	A LETTER OF EXPLANATION WILL FOLLOW SEPARATELY.	PR	96
4W	YOUR PLAN DOES NOT COVER CHARGES FOR HEARING AIDS AND/OR EXAMINATIONS FOR THE FITTING OF THE HEARING AID. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	96
4X	THE AMOUNT "NOT ALLOWED" RESULTS FROM FAILURE TO COMPLY WITH THE PRE-ADMISSION TESTING PROVISIONS OF YOUR PLAN.	PR	B5
4Y	ACCORDING TO OUR RECORDS, THE PLAN DID NOT RECEIVE NOTIFICATION WITHIN THE REQUIRED TIME FRAME. THEREFORE, YOUR BENEFITS HAVE BEEN REDUCED IN ACCORDANCE WITH THE PROVISIONS OF THE PLAN.	CO	62
4Z	THE EXCLUDED AMOUNT IS THE DIFFERENCE BETWEEN THE HEALTH CARE PROVIDER'S CONTRACTED NETWORK FEE AND THE AMOUNT BILLED. YOU ARE NOT RESPONSIBLE FOR PAYING THIS AMOUNT. IF YOU HAVE ALREADY PAID THIS AMOUNT, PLEASE CONTACT OUR CUSTOMER CARE CENTER AT THE NUMBER SHOWN ABOVE.	CO	A2
40	ACCORDING TO OUR RECORDS, WE HAVE NOT BEEN NOTIFIED THAT A SECOND OPINION CONFIRMING THE NEED FOR THIS SURGERY WAS OBTAINED PRIOR TO THE SURGERY MORE INFORMATION, PLEASE REVIEW YOUR PLAN BOOKLET OR CONTACT THE CLAIM OFFICE.	OA	61
41	YOUR BENEFITS SHOULD BE LOWER, BUT YOUR EMPLOYER HAS ASKED US TO USE THE NETWORK LEVEL FOR PAYMENT. WE WILL USE THE OUT-OF-NETWORK LEVEL FOR PAYMENT IN THE FUTURE.	CO	42
44			
46			
47			

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48	EXPENSES FOR ROUTINE EXAMINATIONS, IMMUNIZATIONS AND SIMILAR SERVICES ARE NOT COVERED BY YOUR PLAN.	PR	49
49	THIS CLAIM WAS REFERRED TO MANAGED HEALTH NETWORK, INC. FOR REVIEW. THEY WILL NOTIFY YOU ONCE A DETERMINATION IS MADE.	OA	133
5A	YOUR CLAIM HAS BEEN FORWARDED TO HEALTH INTERNATIONAL FOR ADDITIONAL REVIEW. IF YOU HAVE ANY QUESTIONS, PLEASE CALL HEALTH INTERNATIONAL AT 1-800-638-9599.	CO	B11
5B	YOUR CLAIM HAS BEEN FORWARDED TO HEALTH INTERNATIONAL TO DETERMINE MEDICAL NECESSITY. IF YOU HAVE ANY QUESTIONS, PLEASE CALL HEALTH INTERNATIONAL AT 1-800-638-9599. HEALTH INTERNATIONAL HAS BEEN RETAINED BY AMERICAN AIRLINES AND IS NOT AFFILIATED WITH UNITEDHEALTHCARE.	CO	B11
5C	ACCORDING TO YOUR PLAN, CHARGES FOR OR RELATED TO INFERTILITY ARE NOT COVERED.	PR	96
5D	ACCORDING TO OUR RECORDS, YOUR MEDICAL MAXIMUM HAS BEEN EXHAUSTED THEREFORE NO FURTHER BENEFITS ARE AVAILABLE.	PR	35
5E	THIS EXPENSE WAS RECEIVED AFTER THE TWO YEAR FILING LIMITATION THEREFORE, IT IS NOT COVERED.	PR	29
5F	ACCORDING TO YOUR CONTRACT, CLAIMS MUST BE SUBMITTED WITHIN THE TIMELY FILING LIMIT. AFTER REVIEWING YOUR APPEAL, IT WAS DETERMINED THAT THE INFORMATION SUBMITTED DOES NOT MEET THE REQUIREMENTS TO OVERTURN THE INITIAL CLAIM DENIAL. THEREFORE, NO PAYMENT WILL BE MADE. THE MEMBER IS NOT RESPONSIBLE FOR THESE CHARGES.	OA	138
5H	THE EXCLUDED AMOUNT REPRESENTS CHARGES IN EXCESS OF THE SPECIAL DISCOUNT AGREEMENT BETWEEN AMERICAN AIRLINES AND THE PROVIDER OF SERVICE. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.	CO	A2
5G	THE SUBMITTED MODIFIER IS NOT APPROPRIATE WHEN REPORTED WITH THE CPT-4 CODE OR HCPCS CODE FOR THE RENDERED SERVICE IN A FACILITY PLACE OF SERVICE.	CO	4
5I	THE EXCLUDED AMOUNT REPRESENTS CHARGES IN EXCESS OF THE SPECIAL DISCOUNT NEGOTIATED BETWEEN HEALTH INTERNATIONAL AND THE PROVIDER OF SERVICE. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.	CO	A2
5J	ALL TOTAL CARE PARTICIPANTS LIVING IN, USING PROVIDERS OR RECEIVING THIS TYPE OF SERVICE WITHIN THE SERVICE AREA MUST USE UNIVERSITY CENTER IMAGING. THEREFORE, NO BENEFITS ARE PAYABLE.	PR	96
5K	THIS PROVIDER IS A PARTICIPANT OF THE HOUSTON HEALTHCARE PURCHASING ORGANIZATION AND IS RESPONSIBLE FOR SENDING CLAIMS TO THEM. THE PROVIDER HAS BEEN NOTIFIED TO FORWARD THIS CLAIM TO P.O. BOX 549002, DALLAS, TEXAS 75354 FOR REVIEW.	CO	B11
5L	THIS IS A REDUCTION BASED ON AN AGREEMENT BETWEEN THE HOUSTON HEALTHCARE PURCHASING ORGANIZATION AND YOUR PROVIDER. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.	CO	A2
5M	MEDICARE PAYS BENEFITS BEFORE YOUR GROUP HEALTH PLAN. SINCE THE PATIENT USED A PROVIDER WHO OPTED OUT OF MEDICARE, WE PROCESSED THIS CLAIM AFTER ESTIMATING HOW MUCH MEDICARE PARTS A AND/OR B WOULD HAVE COVERED. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE BILLED CHARGE AND THE AMOUNT PAID BY THIS PLAN.	PR	22
5N	THE PRESCRIPTION DRUG PROGRAM PROVIDES REIMBURSEMENT FOR A LISTING OF DRUGS SPECIFIED BY YOUR EMPLOYER. SINCE THIS DRUG WAS NOT ON THE LIST, THIS EXPENSE DOES NOT QUALIFY FOR COVERAGE UNDER THE PRESCRIPTION DRUG PLAN.	PR	96
5O	TO DETERMINE THE CORRECT BENEFIT FOR THIS ITEM UNDER YOUR PLAN, PLEASE SEND US A COPY OF THE MANUFACTURER'S INVOICE	OA	16
5P	THE SERVICES ON THIS CLAIM SPAN A CALENDAR YEAR CHANGE. THE ACTUAL CHARGES AND BENEFITS FOR THIS CLAIM ARE ACCURATELY REFLECTED ON THE PRIOR YEAR'S PORTION OF THIS CLAIM. THIS PORTION OF THE CLAIM IS PROCESSED FOR STATISTICAL PURPOSES ONLY.	OA	42
5Q	THESE CHARGES ARE INCLUDED IN THE GLOBAL DELIVERY FEE AND WILL BE CONSIDERED WHEN WE RECEIVE THE GLOBAL DELIVERY CLAIM.	PR	97
5R	THE PROVIDER HAS NO CONTRACTUAL ALLOWANCE FOR THIS SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THIS CHARGE.	CO	B7
5S	WHEN THIS PLAN IS THE SECONDARY COVERAGE, WE COORDINATE BENEFITS BASED ON THE PRIMARY CARRIER'S ALLOWABLE AMOUNT. ANY MEMBER RESPONSIBILITY ALSO IS BASED ON THIS AMOUNT.	PR	22
5T	PLEASE SUBMIT THESE CHARGES TO MANAGED HEALTH NETWORK FOR REVIEW. IF YOU HAVE ANY QUESTIONS, PLEASE CALL 1-800-999-3610.	CO	109
5U	THIS AMOUNT REPRESENTS INTEREST PAID.	OA	85
5V	UNITED HEALTHCARE IS NOT THE CARRIER FOR THIS TYPE OF EXPENSE.	PR	109

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5W	PLEASE RESUBMIT THIS CLAIM TO THE APPROPRIATE CARRIER. THE PROVIDER MUST FAX UNITEDHEALTHCARE VISION CLAIMS TO 1-877-826-9300 FOR BENEFIT CONSIDERATION.	CO	109
5X	IN THIS INSTANCE, BENEFITS WILL BE CONSIDERED USING THE FEE-FOR-SERVICE PAYMENT METHOD. THE MEMBER IS ONLY RESPONSIBLE FOR THE COPAY AND ANY APPLICABLE COINSURANCE AND DEDUCTIBLE.	CO	45
5Y	THIS PROVIDER HAS ACCEPTED A DISCOUNT ON YOUR BILL. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE DISCOUNTED AMOUNT. YOU ARE RESPONSIBLE FOR ANY DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	CO	A2
5Z	BASED ON THE ADDITIONAL INFORMATION WE RECEIVED, WE HAVE RECONSIDERED AND APPROVED THESE CHARGES.		
50	MEDICARE PAYS BENEFITS BEFORE YOUR GROUP HEALTH PLAN. SINCE THE PATIENT DID NOT ENROLL FOR MEDICARE PARTS A AND/OR B, WE PROCESSED THIS CLAIM AFTER ESTIMATING HOW MUCH MEDICARE PARTS A AND/OR B WOULD HAVE COVERED. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE BILLED CHARGE AND THE AMOUNT PAID BY THIS PLAN.	CO	22
51	THE PLAN BENEFIT FOR THESE SERVICES WAS DETERMINED BY USING THE AMOUNT APPROVED BY MEDICARE. THIS PHYSICIAN OR HEALTH CARE PROFESSIONAL HAS AGREED TO ACCEPT THAT AMOUNT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	CO	23
52	YOUR PLAN COVERS THE COST OF ONE APPLIANCE NEEDED TO REPLACE A BODY PART OR HELP IT FUNCTION. CHARGES FOR THE REPAIR OF THESE APPLIANCES ARE NOT COVERED BY YOUR PLAN.	PR	96
53	ACCORDING TO YOUR PLAN, ONLY DRUGS THAT REQUIRE A PRESCRIPTION ARE COVERED.	PR	96
54	IF YOU HAVE NOT ALREADY DONE SO, PLEASE SEND US AN ITEMIZED BILL FROM THE PROVIDER OF SERVICE. WE CANNOT ACCEPT CASH REGISTER RECEIPTS, BALANCE DUE BILLS OR CANCELED CHECKS AS PROOF OF MEDICAL EXPENSES.	OA	16
55	YOUR PLAN DOES NOT COVER THIS NON-MEDICAL SERVICE OR PERSONAL ITEM.	PR	96
56	HEARING AIDS AND DENTAL APPLIANCES ARE NOT COVERED BY YOUR PLAN.	PR	96
57	WE HAVE PROCESSED THESE CHARGES BY COORDINATING THE BENEFITS YOU RECEIVED FROM YOUR OTHER INSURANCE PLAN WITH THE BENEFITS AVAILABLE UNDER THIS PLAN.	OA	23
58	COORDINATION OF BENEFITS IS APPLICABLE WHERE AN EMPLOYEE OR DEPENDENT IS COVERED UNDER TWO OR MORE GROUP PLANS. OUR PAYMENT IS BASED ON AN ESTIMATE OF THE BENEFITS PAYABLE BY ANOTHER PLAN. IF OUR ESTIMATE IS INACCURATE, PLEASE SEND US PROOF OF PAYMENT MADE BY THE OTHER PLAN AND WE WILL RECOMPUTE OUR BENEFITS.	PR	22
59	THE BENEFIT FOR THESE SERVICES IS BASED ON THE AMOUNT PAID BY MEDICARE. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWED AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS.	PR	23
6A	THE PROCEDURE CODES SUBMITTED WERE RECODED INTO A MORE ACCURATE PROCEDURE CODE OR THE CODE WAS PAID AT A LOWER E&M LEVEL. IF ADDITIONAL PAYMENT IS WARRANTED, PLEASE SEND THE CLAIM AND DOCUMENTATION TO UNITED NY/NJ, P.O.BOX 452049, SUNRISE FL 33345-2049, OR FAX TO 1-800-600-3899.	OA	97
6B	ADDITIONAL DOCUMENTATION IS NEEDED TO PROCESS THIS CLAIM. PLEASE REFER TO THE LETTER SENT BY MAGELLAN SPECIALITY HEALTH IN THE NEXT THREE DAYS FOR REQUIRED INFORMATION. PLEASE SEND THE CLAIM AND THIS DOCUMENTATION TO UNITED NY/NJ, P.O. BOX 452049, SUNRISE FL, 33345-2049, OR FAX TO 1-800-600-3899.	OA	16
6C	THIS ITEMIZED SERVICE HAS BEEN ADJUSTED TO REFLECT MORE ACCURATELY THE SERVICE(S) PROVIDED. PLEASE REFER TO THE LETTER SENT BY MAGELLAN SPECIALITY HEALTH IN THE NEXT THREE DAYS FOR REQUIRED INFORMATION. PLEASE SEND THE CLAIM AND THIS DOCUMENTATION TO UNITED NY/NJ, P.O.BOX 452049, SUNRISE FL 33345-2049, OR FAX TO 1-800-600-3899.	CO	109
6D	THIS PROCEDURE OR SUPPLY IS PART OF THE MAIN PROCEDURE. THE CHARGES ARE NOT COVERED SEPARATELY. PLEASE REFER TO THE LETTER SENT BY MAGELLAN SPECIALITY HEALTH IN THE NEXT THREE DAYS FOR REQUIRED INFORMATION. PLEASE SEND THE CLAIM AND THIS DOCUMENTATION TO UNITED NY/NJ, P.O.BOX 452049, SUNRISE FL 33345-2049, OR FAX TO 1-800-600-3899.	OA	B15
6F	THESE EXPENSES CANNOT BE CONSIDERED FOR PAYMENT BECAUSE THE	PR	119

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6G	MAXIMUM REIMBURSEMENT AMOUNT HAS BEEN PAID FOR THIS CALENDAR YEAR. NO FURTHER BENEFITS ARE AVAILABLE FOR THIS CALENDAR YEAR. OUR RECORDS SHOW THAT HIGHMARK IS RESPONSIBLE FOR YOUR MEDICAL COVERAGE. THIS, AND ANY FUTURE CLAIMS, SHOULD BE SUBMITTED DIRECTLY TO: HIGHMARK, P.O. BOX 890381, CAMP HILL, PA, 17089. IF YOU HAVE QUESTIONS, PLEASE CALL THEM AT 1-866-267-3320.	PR	109
6H	PLEASE SEND US A RECEIPT, BILL OR STATEMENT FOR THIS EXPENSE, INCLUDING THE DATE OF PURCHASE, ALONG WITH THIS EXPLANATION OF BENEFITS STATEMENT, TO THE ADDRESS SHOWN ABOVE. THIS INFORMATION IS REQUIRED BEFORE BENEFITS CAN BE CONSIDERED.	OA	16
6I	PLEASE PROVIDE THE PRODUCT CODE FOR THIS EXPENSE ON THIS EXPLANATION OF BENEFITS STATEMENT AND RETURN IT TO US AT THE ADDRESS SHOWN ABOVE. THE PRODUCT CODE IS LOCATED ON THE LENS BOX. THIS INFORMATION IS REQUIRED BEFORE BENEFITS CAN BE CONSIDERED.	OA	16
6J	PLEASE PROVIDE THE TYPE OF LENS, THE WEAR SCHEDULE AND THE NUMBER OF CONTACT LENS BOXES PURCHASED ON THIS EXPLANATION OF BENEFITS STATEMENT AND RETURN IT TO US AT THE ADDRESS SHOWN ABOVE. THIS INFORMATION IS REQUIRED BEFORE BENEFITS CAN BE CONSIDERED.	OA	16
6K	WE RECEIVED A CLAIM WITH A TAX IDENTIFICATION NUMBER THAT IS NOT ON FILE WITH ACN GROUP. THE HEALTH CARE PROVIDER MUST SUBMIT A W-9 FORM TO ACN GROUP. THIS CLAIM MUST BE SUBMITTED FOR PAYMENT WITHIN THE CLAIM FILING LIMITS.	CO	16
6L	OUR RECORDS SHOW THAT REGENCE LIFE & HEALTH IS RESPONSIBLE FOR YOUR MEDICAL COVERAGE. THIS, AND ANY FUTURE CLAIMS, SHOULD BE SUBMITTED DIRECTLY TO: REGENCE LIFE & HEALTH, P.O. BOX 1071, MAIL STATION 4U, PORTLAND, OR, 97207. IF YOU HAVE QUESTIONS, PLEASE CALL THEM AT 1-888-977-2583.	PR	109
6M	OUR RECORDS SHOW THAT AETNA US HEALTHCARE IS RESPONSIBLE FOR YOUR MEDICAL COVERAGE. THIS, AND ANY FUTURE CLAIMS, SHOULD BE SUBMITTED DIRECTLY TO: AETNA US HEALTHCARE, P.O. BOX 7064, SOUTH BAY RD, SUITE 1A, DOVER, DE, 19903. IF YOU HAVE QUESTIONS, PLEASE CALL THEM AT 1-888-332-8742.	PR	109
6N	THESE SERVICES ARE ADMINISTERED BY MANAGED HEALTH NETWORK. THEREFORE, NO BENEFITS ARE PAYABLE AT THIS TIME. PLEASE SUBMIT THIS CLAIM DIRECTLY TO: MANAGED HEALTH NETWORK, PO BOX 14621, LEXINGTON, KY 40512-4621. IF YOU HAVE QUESTIONS, PLEASE CALL THEM AT 1-888-267-5261.	CO	109
6O	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR ORTHOTIC APPLIANCES (INCLUDING SHOE ORTHOTICS).	PR	96
6P	WE HAVE APPLIED THE CONTRACTED RATE FOR THIS SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THE EXCLUDED AMOUNT.	CO	A2
6Q	THE EXCLUDED AMOUNT REPRESENTS A REDUCTION IN CHARGES AGREED TO BY THE PROVIDER OF SERVICE. THE MEMBER IS NOT RESPONSIBLE FOR THE EXCLUDED AMOUNT.	CO	A2
6R	WE HAVE RECONSIDERED YOUR VISION CLAIM ACCORDING TO THE TERMS OF YOUR BENEFIT PLAN. SINCE YOU HAVE USED A NON-PARTICIPATING PROVIDER, BENEFITS HAVE BEEN DETERMINED AT THE OUT-OF-NETWORK LEVEL.	OA	38
6S	OUR RECORDS SHOW THAT MAGELLAN BEHAVIORAL HEALTH IS RESPONSIBLE FOR YOUR MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE. THIS, AND ANY FUTURE CLAIMS, SHOULD BE SUBMITTED DIRECTLY TO: MAGELLAN BEHAVIORAL HEALTH, P.O. BOX 5234, COLUMBIA, MD, 21046-5234. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THEM AT 1-888-724-5006.	PR	109
6T	WE HAVE RECONSIDERED THESE CHARGES BECAUSE OF ADDITIONAL INFORMATION WE RECEIVED.		
6U	YOU HAVE USED A NON-PARTICIPATING VISION PROVIDER. WE HAVE CONSIDERED THIS EXPENSE ACCORDING TO THE TERMS OF YOUR BENEFIT PLAN.	OA	38
6V	THE AMOUNT NOT COVERED EXCEEDS THE SCHEDULED AMOUNT PAYABLE UNDER THE LENS REIMBURSEMENT PROGRAM.	PR	42
6W	IN ACCORDANCE WITH TEXAS LAW, INTEREST/PENALTY HAS BEEN APPLIED.	OA	96
6X	THE NUMBER OF UNITS REPORTED EXCEEDS THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE. THEREFORE, THE NUMBER OF UNITS THAT EXCEED THE TYPICAL FREQUENCY PER DAY IS NOT BEING CONSIDERED. IF THE PROVIDER HAS ADDITIONAL DOCUMENTATION, PLEASE SEND IT TO US FOR CONSIDERATION.	PR	57
6Y	THIS PROVIDER IS NOT A VALUEOPTIONS NETWORK PROVIDER, HOWEVER, THEY HAVE AGREED TO A REDUCTION IN CHARGES ON THIS OUTPATIENT CLAIM. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE	CO	131

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	AMOUNT CHARGED BY THE PROVIDER AND THE AMOUNT ALLOWED. YOU ARE RESPONSIBLE FOR ANY APPLICABLE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.		
6Z	THIS FACILITY IS NOT A VALUEOPTIONS NETWORK PROVIDER, HOWEVER, THEY HAVE AGREED TO A REDUCTION IN CHARGES ON THIS INPATIENT CLAIM. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PROVIDER AND THE AMOUNT ALLOWED. YOU ARE RESPONSIBLE FOR ANY APPLICABLE DEDUCTIBLE AND COINSURANCE AMOUNTS THAT HAVE NOT BEEN MET.	CO	131
60	THIS CLAIM HAS BEEN REPROCESSED USING THE APPROPRIATE PROVIDER DISCOUNT. THE PHYSICIAN OR OTHER HEALTH CARE PROVIDER'S CONTRACTED RATE MAY BE LESS THAN THE AMOUNT PREVIOUSLY PAID. IF THERE HAS BEEN AN OVERPAYMENT, THE PATIENT MAY BE ENTITLED TO A REFUND FROM THE PHYSICIAN OR OTHER HEALTH CARE PROVIDER.		
61	ACCORDING TO YOUR PLAN, EXAMINATIONS, CONSULTATIONS, AND NON-SURGICAL TREATMENTS PERFORMED IN THE PATIENT'S HOME, THE DOCTOR'S OFFICE, OR OUTPATIENT AT ANY FACILITY ARE NOT COVERED.	PR	96
62	THIS ADDITIONAL PAYMENT IS BEING MADE IN ACCORDANCE WITH THE COORDINATION OF BENEFITS (COB) LANGUAGE REGARDING A SPOUSE COVERED UNDER THE RAILROAD EMPLOYEES NATIONAL EARLY RETIREMENT PLAN OR RAILROAD EMPLOYEES NATIONAL HEALTH AND WELFARE PLAN AS DESCRIBED IN THE NRC/UTU SUMMARY PLAN DESCRIPTION.	PR	22
63	THE AMOUNT CONSIDERED HAS BEEN DISCOUNTED FOR PROMPT PAYMENT. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE BILLED AMOUNT AND THE DISCOUNTED AMOUNT.	CO	44
64	THE CONTRACTED AMOUNT FOR THIS CLAIM WAS PREVIOUSLY ALLOWED AND HAS BEEN ISSUED SEPARATELY. NO FURTHER PAYMENT IS DUE ON THIS PORTION OF THE CLAIM. THE PATIENT IS NOT RESPONSIBLE FOR THESE CHARGES.	OA	A2
65	ACCORDING TO YOUR PLAN, THERE IS A LIMITED BENEFIT FOR THIS EXPENSE. PAYMENT IS BASED ON THIS LIMITED BENEFIT.	PR	35
67			
68			
69			
7A	THE SAME QUALIFYING CIRCUMSTANCES PROCEDURE CODE(S) WAS SUBMITTED MORE THAN ONCE FOR THIS ANESTHESIA DELIVERY SERVICE. ONLY ONE QUALIFYING CIRCUMSTANCES PROCEDURE CODE IS BEING CONSIDERED IN THE BENEFIT CALCULATION. THE AMOUNT CHARGED FOR THE OTHER SAME QUALIFYING CIRCUMSTANCE PROCEDURE CODE(S) IS BEING DENIED AS A DUPLICATE.	OA	B15
7B	THE ANESTHESIA DELIVERY SERVICE CODE INCLUDES THE AMOUNT CHARGED FOR THE QUALIFYING CIRCUMSTANCES. BENEFITS ARE BASED ON THIS CODE.	CO	97
7C	THIS CLAIM HAS BEEN SUBMITTED TO THE INCORRECT CLAIMS OFFICE. SEND CLAIMS FOR THIS PATIENT TO: SPECIALTY NETWORKS, MAIL ROUTE MN010-N169, P.O. BOX 1459, MINNEAPOLIS, MN 55440-1459.	CO	109
7D	URN ONCOLOGY NETWORK CONTRACT AGREEMENT.	CO	A2
7E	BASED ON THE INFORMATION PROVIDED, THIS SERVICE IS UNPROVEN AND IS NOT COVERED. THEREFORE, NO BENEFITS ARE PAYABLE FOR THIS EXPENSE. IN ORDER FOR THIS SERVICE TO BE CONSIDERED FOR COVERAGE, YOU MUST SUBMIT SCIENTIFIC EVIDENCE, THAT MEETS THE STANDARDS DESCRIBED IN YOUR BENEFIT PLAN LANGUAGE, THAT DEMONSTRATES THE SAFETY AND EFFECTIVENESS OF THIS SERVICE FOR YOUR PARTICULAR CONDITION.	PR	56
7F	THE PLAN IN WHICH YOU ARE ENROLLED DOES NOT COORDINATE BENEFITS WITH YOUR PRIMARY COVERAGE. THEREFORE, NO BENEFITS ARE AVAILABLE.	CO	22
7G	ACCORDING TO YOUR CONTRACT, APPEALS MUST BE SUBMITTED WITHIN THE TIMELY FILING LIMIT. THIS APPEAL WAS RECEIVED BEYOND THE APPEAL DEADLINE, AND THEREFORE, WILL NOT BE CONSIDERED.	OA	138
7H	PURSUANT TO TEXAS INSURANCE REGULATIONS, ENCLOSED IS A CHECK REPRESENTING PENALTY PAYMENT FOR THIS CLAIM WHICH WAS PAID BEYOND THE PROMPT PAY LIMIT OF 45 DAYS FOR WHICH PENALTY WAS NOT PREVIOUSLY PAID.	OA	44
7I	ACCORDING TO OUR RECORDS, YOU HAVE REACHED THE MAXIMUM BENEFIT ALLOWED FOR INFERTILITY EXPENSES COVERED UNDER YOUR PLAN.	PR	35
7J			
7K	WE HAVE RECONSIDERED THESE CHARGES BECAUSE OF ADDITIONAL INFORMATION WE HAVE RECEIVED.		
7L	ACCORDING TO YOUR PREFERRED PROVIDER OPTION (PPO) PLAN, OFFICE VISITS ARE PAID AT A PERCENTAGE OF THE ALLOWED AMOUNT.	PR	42
7M	ACCORDING TO YOUR PLAN, CHEMOTHERAPY IS NOT COVERED WHEN	PR	96

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7N	ADMINISTERED BY THIS METHOD, OR FOR THIS CONDITION. YOUR BENEFIT PLAN COVERS ONE ROUTINE PHYSICAL EXAMINATION PER CALENDAR YEAR. ACCORDING TO OUR RECORDS, WE HAVE ALREADY COVERED YOUR ROUTINE PHYSICAL FOR THIS CALENDAR YEAR. THEREFORE, NO ADDITIONAL BENEFITS ARE PAYABLE.	CO	119
7O	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR PERSONAL COMFORT ITEMS, INCLUDING AIR CONDITIONERS AND HUMIDIFIERS, EVEN THOUGH PRESCRIBED BY A PHYSICIAN.	PR	96
7P	THE AMOUNT ALLOWED IS INTENDED TO BE PAYMENT IN FULL FOR COVERED SERVICES.	CO	45
7Q	ACCORDING TO YOUR PLAN, YOU ARE REQUIRED TO FOLLOW A PREDETERMINATION PROCESS FOR THIS SERVICE. SINCE THE PROCESS WAS NOT COMPLETED, BENEFITS HAVE BEEN REDUCED.	CO	62
7R	ACCORDING TO YOUR PLAN, THE MAXIMUM BENEFIT FOR THIS SERVICE HAS BEEN ALLOWED. THE INDIVIDUAL IS NOT RESPONSIBLE FOR ANY ADDITIONAL CHARGES FOR THE HEARING AID OR DISPENSING FEE.	CO	35
7S	ACCORDING TO YOUR PLAN, BENEFITS ARE LIMITED TO ONE HEARING AID AND THE ASSOCIATED SERVICES WITHIN A 36 CONSECUTIVE MONTH PERIOD.	PR	119
7T	ADDITIONAL PENALTY PAYMENT BASED ON MISSOURI PROMPT PAY STATUTE FOR DETERMINATIONS BEYOND 40 PROCESSING DAYS.	OA	44
7U	THIS CLAIM DID NOT MEET THE STATE CRITERIA FOR THE APPLICABLE LATE PAYMENT PENALTY. NO PENALTY IS PAYABLE.	CO	96
7V	ACCORDING TO TEXAS LAW, WE ORIGINALLY ISSUED PARTIAL PAYMENT. WE RECEIVED ADDITIONAL INFORMATION AND HAVE REPROCESSED YOUR CLAIM.		
7W	SINCE THE 60 DAY APPEAL REVIEW PERIOD HAS ELAPSED, WE PAID THIS CLAIM IN ACCORDANCE WITH THE NY UTILIZATION REVIEW LAW. THIS PAYMENT DOES NOT MEAN THAT THE SAME BENEFIT WILL BE AVAILABLE FOR FUTURE SIMILAR CLAIMS THAT ARE REVIEWED WITHIN THE 60 DAY REVIEW PERIOD.	CO	96
7X	THIS DENTAL EXPENSE IS NOT COVERED UNDER THIS GROUP HEALTH PLAN. TO AVOID DELAYS, PLEASE SUBMIT ALL DENTAL CLAIMS TO: UNITEDHEALTHCARE, P.O. BOX 30560, BETHESDA, MD 20824-0560.	PR	109
7Y			
7Z	THIS SERVICE OR SUPPLY IS PART OF A MAIN PROCEDURE AND IS NOT COVERED SEPARATELY.	OA	B15
70			
71			
72	ACCORDING TO YOUR VISION PLAN, THE ABOVE SERVICES ARE COVERED ONCE WITHIN A SPECIFIED PERIOD. IN YOUR BENEFITS BOOKLET, PLEASE REFER TO THE SECTION THAT COVERS TIME LIMITATIONS FOR VISION BENEFITS.	PR	119
73	PLEASE HAVE THE HOSPITAL SEND THESE CHARGES TO BLUE CROSS FOR PAYMENT.	PR	109
74			
75			
76			
77			
78			
79			
8A	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR SEX TRANSFORMATION OPERATIONS.	PR	96
8B	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR REVERSAL OF VOLUNTARY STERILIZATION'S.	PR	96
8C	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR SURROGATE PARENTING.	PR	96
8D	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR AMNIOCENTESIS THAT DOES NOT MEET COVERAGE REQUIREMENTS.	PR	50
8E	YOUR PLAN DOES NOT COVER ACUPUNCTURE.	PR	96
8F	YOUR PLAN DOES NOT COVER ACUPRESSURE.	PR	96
8G	YOUR PLAN DOES NOT COVER HYPNOTISM.	PR	96
8H	YOUR PLAN DOES NOT COVER ROLFING.	PR	96
8I	YOUR PLAN DOES NOT COVER MASSAGE THERAPY.	PR	96
8J	YOUR PLAN DOES NOT COVER AROMATHERAPY.	PR	96
8K	YOUR PLAN DOES NOT COVER COSTS AND EXPENSES FOR FITTING OF EYEGASSES OR CONTACT LENSES.	PR	96
8L	YOUR PLAN DOES NOT COVER THIS THERAPY SERVICE OR ASSOCIATED EXPENSE.	PR	96
8M	YOUR PLAN DOES NOT COVER THIS MAMMOGRAPHY SERVICE OR ASSOCIATED EXPENSE.	PR	96
8N	YOUR PLAN DOES NOT COVER THIS ROUTINE FOOT CARE SERVICE OR	PR	96

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	ASSOCIATED EXPENSE.		
8O	YOUR PLAN DOES NOT COVER THIS SURGICAL PROCEDURE OR ASSOCIATED EXPENSE.	PR	96
8P	YOUR PLAN DOES NOT COVER THIS CONTRACEPTIVE SERVICE OR ASSOCIATED EXPENSE.	PR	96
8Q	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR SPECIMEN HANDLING.	PR	96
8R	YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR REPORTS, FORMS, TESTS, OR ANALYSIS OF DATA.	PR	96
8S	YOUR PLAN DOES NOT COVER THIS VISIT, CONSULTATION, EVALUATION AND MANAGEMENT, OR ASSOCIATED EXPENSES.	PR	B1
8T	YOUR PLAN DOES NOT COVER THIS MENTAL HEALTH/SUBSTANCE ABUSE SERVICE OR ASSOCIATED EXPENSE.	PR	96
8U	YOUR PLAN DOES NOT COVER THIS DIALYSIS SERVICE OR ASSOCIATED EXPENSE.	PR	96
8V	YOUR PLAN DOES NOT COVER THIS CARDIAC OR CARDIOVASCULAR SERVICE, OR ASSOCIATED EXPENSE.	PR	96
8W	YOUR PLAN DOES NOT COVER THIS DIAGNOSTIC SERVICE, TEST OR STUDY, OR ASSOCIATED EXPENSE.	PR	96
8X	YOUR PLAN DOES NOT COVER THIS EMERGENCY SERVICE OR ASSOCIATED EXPENSE.	PR	96
8Y	YOUR PLAN DOES NOT COVER THIS VISION OR HEARING SERVICE OR ASSOCIATED EXPENSE.	PR	96
8Z	YOUR PLAN DOES NOT COVER THIS FAMILY PLANNING SERVICE OR ASSOCIATED EXPENSE.	PR	96
80	WE FORWARDED YOUR VISION EXPENSES FOR CONSIDERATION UNDER YOUR VISION PLAN. THEY WILL NOTIFY YOU ONCE A DETERMINATION IS MADE.	OA	B11
81			
82	THIS IS A CORRECTION TO A PRIOR CLAIM. THESE CHARGES WERE ORIGINALLY PROCESSED USING AN INCORRECT PROVIDER.	CR	B20
83	YOUR BENEFIT PLAN COVERS REASONABLE AND MEDICALLY NECESSARY CHARGES FOR APPROPRIATE TREATMENT IN CONNECTION WITH A SICKNESS OR INJURY. THE FREQUENCY AND DURATION OF 'APPROPRIATE TREATMENT' IS ALSO DETERMINED BY, AMONG OTHER THINGS, THE DIAGNOSIS AND SEVERITY OF THE CONDITION. BASED ON AVAILABLE DOCUMENTATION, WE HAVE LIMITED COVERED EXPENSES TO THOSE WHICH APPEAR TO BE MEDICALLY APPROPRIATE.	CO	50
84	WE HAVE REPROCESSED THESE CHARGES. WE ORIGINALLY ESTIMATED THAT THEY WERE COVERED BY ANOTHER INSURANCE PLAN.		
85	ACCORDING TO OUR RECORDS, YOU EITHER HAVE NOT ELECTED CONTINUATION COVERAGE, OR YOUR CURRENT PREMIUM HAS NOT BEEN PAID. IF YOU HAVE ELECTED CONTINUATION COVERAGE AND PAID YOUR PREMIUM, PLEASE CONTACT MEMBER SERVICES AT THE NUMBER SHOWN ON YOUR ID CARD.	PR	96
87	THIS IS A REPLACEMENT CHECK. THE ORIGINAL CHECK SHOULD BE RETURNED TO THE CLAIM OFFICE SHOWN ABOVE.		
88	ACCORDING TO OUR RECORDS, THIS PATIENT WAS NOT COVERED UNDER THIS BENEFIT PLAN WHEN THESE SERVICES WERE RENDERED. THEREFORE, NO BENEFITS ARE PAYABLE.	OA	31
89	AS A RESULT OF A GLOBAL AGREEMENT, BENEFITS PAYABLE FOR THIS CLAIM HAVE BEEN PRE-PAID. THE PATIENT IS STILL RESPONSIBLE FOR ANY APPLICABLE DEDUCTIBLE, COINSURANCE, OR COPAY AMOUNTS.		
9A	YOUR PLAN LIMITS BENEFITS FOR DENTAL SERVICES AND ASSOCIATED EXPENSES. PAYMENT IS BASED ON THIS LIMITED BENEFIT.	PR	119
9B	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR VISION SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9C	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR HEARING SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9D	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR MENTAL HEALTH/ SUBSTANCE ABUSE SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9E	YOUR PLAN LIMITS BENEFITS FOR OUTPATIENT SURGERY SERVICES AND ASSOCIATED EXPENSES. PAYMENT IS BASED ON THIS LIMITED BENEFIT.	PR	119
9F	YOUR PLAN LIMITS BENEFITS FOR MEDICARE INPATIENT DEDUCTIBLE. PAYMENT IS BASED ON THIS LIMITED BENEFIT.	PR	119
9G :PR		119	3
	PATHOLOGY SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.		
9H	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR MEDICATIONS	PR	119

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	AND DIAGNOSTIC OR THERAPEUTIC INJECTION SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.		
9I	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR ANESTHESIA SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9J	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR RADIOLOGY SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9K	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR MEDICAL SUPPLIES, PROSTHETICS, ORTHOTIC APPLIANCES AND OR DURABLE MEDICAL EQUIPMENT HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.		
9L	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR THIS THERAPY BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9M	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR MAMMOGRAPHY SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9N	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR NURSING SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9O	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR SURGICAL PROCESURES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9P	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR PRESCRIPTION DRUGS AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9Q	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR INPATIENT SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9R		PR	119
9S	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR VISITS, CONSULTATIONS, EVALUATION AND MANAGEMENT SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9T	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR INPATIENT PHYSICIAN SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9U	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR OUTPATIENT PHYSICIAN SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9V	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR EMERGENCY FACILITY AND PHYSICIAN SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
9Z	ACCORDING TO OUR RECORDS, YOUR ANNUAL MAXIMUM BENEFIT FOR FAMILY PLANNING SERVICES AND ASSOCIATED EXPENSES HAS BEEN PAID. THEREFORE, NO FURTHER BENEFITS ARE PAYABLE FOR THIS BENEFIT PERIOD.	PR	119
97		PR	96