

PROFESSIONAL EDIT EXPLANATION DOCUMENT

ERROR NUMBER	AUDIT REPORT MESSAGE	EXPLANATION
001	INVALID SUBMITTER ID	IN ISA05 THERE IS MORE THAN ONE SPACE IN THE AGENCY ID FIELD.
003	SUBMITTER ID NOT APPROVED FOR PRODUCTION	THE SUBMITTER ID SUBMITTED IS NOT APPROVED TO SEND PRODUCTION FILES.
004	PRODUCTION/TESTING INDICATOR IN THE ISA DOES NOT MATCH THE FILE NAME	THE ISA 15 DOES NOT MATCH THE FILE NAME (EX. ISA15 SHOWS P, BUT THE FILE NAME IS TBPC001.CLM).
109	NPI NUMBER IS MISSING	AN NPI MUST BE SUBMITTED ON ANY ELECTRONIC CLAIM.
111	THIS LINE/CLAIM/BILLING NPI (XXXXXXXXXX) IS AN INVALID FORMAT	THIS IS ISSUED WHEN NPI IS IN AN INVALID FORMAT.
200	INVALID CONTRACT NUMBER FORMAT	THE FORMAT FOR CONTRACT NUMBERS MUST CONTAIN AN ALPHABETIC PREFIX, NOT NUMERIC, OR THE CONTRACT NUMBER IS NOT VALID TO BE PROCESSED IN ALABAMA AND IS NOT PART OF THE BLUECARD NETWORK.
201	INVALID CONTRACT NUMBER	CONTRACT NUMBER DOES NOT MATCH BLUE SHIELD CONTRACT NUMBER IN THE SYSTEM FOR SUBSCRIBER (E.G. CANNOT USE XAD PREFIX FOR BLUE SHIELD) ** THIS EDIT IS BYPASSED FOR FEP PREFIXES (R) AND WRI ALONG WITH NASCO PROGRAM CONTRACTS.
202	INSUR(XXXXXXXXXXXX) INVALID	THE NAME OR VALUE INCLUDED IN THE PARENTHESIS WAS RECEIVED IN THE INSURED'S LAST NAME FIELD. IF THE CHARACTERS ARE THE INSURED'S FIRST NAME, THEN THE LAST AND FIRST NAMES ARE MOST LIKELY REVERSED. IF THE PARENTHESSES ARE BLANK, THEN THE INSURED'S LAST NAME FIELD WAS LEFT BLANK. ANY CHARACTERS WITHIN THE PARENTHESSES REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
203	"XAD" PREFIX INVALID - DNTL USE ONLY	THE XAD PREFIX IS ASSIGNED TO DENTAL CONTRACTS ONLY AND IS NOT A VALID CONTRACT PREFIX FOR PHYSICIAN CLAIMS.

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204	DATE OF BIRTH MISSING OR INVALID	IF PATIENT BIRTH MONTH IS LESS THAN 01 OR GREATER THAN 12, OR BIRTHDAY IS LESS THAN 01 OR GREATER THAN 31, THEN THE CLAIM WILL BE REJECTED. DATE FORMAT IS CCYYMMDD.
206	PATIENT TOO YOUNG TO BE SUBSCRIBER	THE RELATIONSHIP CODE SUBMITTED INDICATES SUBSCRIBER. ONLY CHILDREN UNDER AGE 14 COVERED UNDER THE ALABAMA CARING PROGRAM FOR CHILDREN, ALL KIDS, AND ANY COBRA CONTRACT THAT HAS BEEN CREATED FOR A CHILD UNDER 14, SHOULD BE FILED AS A SUBSCRIBER.
207	PATIENT TOO YOUNG TO BE SPOUSE	IF THE PATIENT'S YEAR OF BIRTH INDICATES THAT THE PATIENT IS UNDER 14, AND THE PATIENT IS SHOWN AS THE SUBSCRIBER'S SPOUSE, THE CLAIM WILL ERROR.
208	SEX OR PATIENT RELATIONSHIP TO INSURED INVALID	THE RELATIONSHIP CODE INDICATES THE RELATIONSHIP BETWEEN THE INSURED AND THE PATIENT. THE SUBMITTED RELATIONSHIP CODE (SUBSCRIBER/PATIENT) AND THE SUBMITTED SUBSCRIBER GENDER CODE DO NOT MATCH THE BLUE CROSS SUBSCRIBER FILE.
209	CLAIMS MUST FIRST BE FILED WITH MEDICARE	AFTER A SEARCH OF THE BLUE CROSS SUBSCRIBER FILE, IF A CONTRACT NUMBER INDICATES THAT THE PATIENT HAS C PLUS COVERAGE AND THE DATES OF SERVICE ARE WITHIN THE CONTRACT COVERAGE PERIOD, THEN THE CLAIM SHOULD BE FIRST FILED WITH MEDICARE.
210	FEP CONTRACT NUMBER FORMAT INVALID	THE FIRST DIGIT OF THE NUMERIC PORTION OF THE CONTRACT NUMBER FOR AN FEP CLAIM MUST BE ZERO. (E.G. CANNOT USE BLUE SHIELD OR XAA PREFIX ON AN FEP CONTRACT).
211	DATE OF BIRTH GREATER THAN SERVICE DATE	DATE OF SERVICE PRECEDES DATE OF BIRTH LISTED ON THE SYSTEM FOR THE INSURED.

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212	FEP CONTRACT NUMBER NOT ON FILE - CALL FEP CUSTOMER SERVICE AT 800-492-8872 TO VERIFY AND HAVE OUT OF STATE CONTRACT ADDED TO LOCAL SYSTEM	CONTRACT NUMBER SUBMITTED IS INVALID. CALL FEP CUSTOMER SERVICE AT 1 800 492-8872.
215	INVALID CLAIM FILING INDICATOR FOR THE PAYER REQUESTING THE PAYMENT - MUST BE 'BL' FOR BLUE CROSS CLAIMS	THE CLAIM FILING INDICATOR (SEGMENT SBR09) IS SOMETHING OTHER THAN 'BL' FOR BLUE CROSS.
300	THIS IS NOT AN ERROR: CORRECTED BILL HAS BEEN ACCEPTED FOR PROCESSING	INDICATES A CORRECTED CLAIM WAS RECEIVED AND ACCEPTED FOR PROCESSING.
301	NO ORIGINAL CLAIM NUMBER SUBMITTED ON CORRECTED BILL	ORIGINAL CLAIM NUMBER SUBMITTED IS NOT NUMERIC OR DOES NOT MATCH A CLAIM UNDER THE CONTRACT OF THE CORRECTED CLAIM.
302	ASSIGNMENT OF BENEFITS INDICATOR MUST BE A,B,C OR P	PROVIDER ACCEPT ASSIGNMENT CODE MUST BE A, B, C OR P.
303	ACCIDENT DT FORMAT INVALID(CCYYMMDD)	INVALID MONTH OR DAY SUBMITTED. FORMAT SHOULD BE CCYYMMDD. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
304	WORK RELATED INJURY FILED WITHOUT ACCIDENT DATE	CLAIM SUBMITTED AS WORKER'S COMPENSATION CLAIM (WRI PREFIX) WITHOUT AN ACCIDENT DATE.
305	DIAG CODE (XXXXX) INVALID NOT ON FILE	DIAGNOSIS CODE SUBMITTED CONTAINS ".", SPACES OR ZEROES OR IS NOT A CURRENT VALID ICD-9 CODE. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
311	REFERRING PROVIDER NAME AND REFERRING PROVIDER IDENTIFIER DO NOT MATCH	THE SUBMITTED REFERRING PROVIDERS' LAST NAME DOES NOT MATCH THE LAST NAME ON THE REFERRING PROVIDER UPIN FILE.

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313	ACCIDENT STATE CODE INVALID	STATE ABBREVIATION FOR THE LOCATION OF THE ACCIDENT WAS INVALID.
314	RELATED CAUSE REQUIRED WHEN ACCIDENT DATE IS PRESENT	AN ACCIDENT DATE WAS PRESENT ON THE CLAIM, BUT NO ACCIDENT REASON WAS SELECTED.
315	PRIMARY INSURANCE INFORMATION MUST BE SUBMITTED FOR A BLUE SHIELD SECONDARY CLAIM.	ELEMENT SBR01 WAS FILED AS SECONDARY 'S', BUT NO PRIMARY INFORMATION WAS FILED.
317	PRIMARY/SECONDARY PAYER PAID AMOUNT REQUIRED FOR SECONDARY/TERTIARY CLAIM	NO PRIMARY PAYER PAID AMOUNT WAS INDICATED ON THE CLAIM. ZERO IS A VALID AMOUNT FOR A PAID AMOUNT.
318	MORE THAN ONE DEDUCTIBLE NOT ALLOWED ON CLAIM WHEN MEDICARE WAS PRIMARY/SECONDARY PAYER	CLAIM WAS FILED WITH MORE THAN ONE DEDUCTIBLE AMOUNT. ONLY ONE DEDUCTIBLE CAN BE PRESENT WHEN PRIMARY PAYER IS MEDICARE.
319	CLAIMS SHOULD HAVE LINE LEVEL PAYMENT INFORMATION WHEN PRIMARY/SECONDARY PAYER WAS MEDICARE	SECONDARY CLAIM FILED WITH MEDICARE PRIMARY MUST HAVE LINE LEVEL PAYMENTS AND ADJUSTMENTS.
320	MORE THAN ONE CO-PAYMENT/COINSURANCE NOT ALLOWED ON CLAIM WITH MEDICARE PRIMARY/SECONDARY	SECONDARY CLAIM FILED WITH MEDICARE PRIMARY CAN ONLY CONTAIN ONE COPAYMENT OR CO-INSURANCE AMOUNTS.
321	MEDICAID CLAIMS CAN NOT BE SUBMITTED AS A PRIMARY OR SECONDARY PAYER	MEDICAID CAN ONLY BE SUBMITTED AS A PAYER OF LAST RESORT.
322	PRIMARY/SECONDARY ALLOWED AMOUNT REQUIRED FOR SECONDARY/TERTIARY CLAIM WHEN PRIMARY/SECONDARY PAYER WAS MEDICARE (2400 AMT)	WHEN MEDICARE IS THE PREVIOUS PAYER, THE MEDICARE ALLOWED AMOUNT IS REQUIRED FOR PROCESSING.

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323	CLAIM BILLING/ RENDERING/REFERRING /SERVICE FACILITY NPI (XXXXXXXXXX) INVALID	NATIONAL PROVIDER IDENTIFIER SUBMITTED IN ONE OF THESE LOOPS IS INCORRECT.
324	MISSING LINE LEVEL DATA FOR PRIMARY/SECONDARY PAYER. IF LINE LEVEL INFORMATION IS SENT ON ONE LINE, IT MUST BE SENT ON ALL LINES.	IF LINE LEVEL INFORMATION IS SENT ON ONE LINE, IT MUST BE SENT FOR EACH SERVICE LINE FILED FOR CONSIDERATION.
325	WHEN CLAIM LEVEL PAID AMOUNT PRESENT IT MUST MATCH THE SUM OF THE LINE LEVEL PAID AMOUNTS.	IF BOTH CLAIM LEVEL AND LINE LEVEL PAID AMOUNTS ARE SENT, THE SUM OF THE LINE LEVEL AMOUNTS MUST MATCH THAT SENT AT THE CLAIM LEVEL.
326	WHEN CLAIM LEVEL ALLOWED AMOUNT PRESENT IT MUST MATCH THE SUM OF THE LINE LEVEL ALLOWED AMOUNTS.	IF BOTH CLAIM LEVEL AND LINE LEVEL ALLOWED AMOUNTS ARE SENT, THE SUM OF THE LINE LEVEL AMOUNTS MUST MATCH THAT SENT AT THE CLAIM LEVEL.
327	PROVIDER TAX ID REQUIRED WITH CLAIM BILLING/CLAIM RENDERING/LINE RENDERING NPI (XXXXXXXXXX)	PROVIDER TAX ID REQUIRED WHEN SENDING NPI.
328	PROVIDER ADDRESS REQUIRED WITH BILLING/PAY-TO/CLAIM BILLING/CLAIM RENDERING/CLAIM SERVICE FACILITY NPI (XXXXXXXXXX)	PROVIDER ADDRESS REQUIRED WITH NPI.
331	CLAIM FILING INDICATOR ZZ IS NOT SPECIFIC ENOUGH. SUBMIT A MORE DESCRIPTIVE VALUE.	'ZZ' IS NOT A VALID CLAIM FILING INDICATOR SUBMITTED IN SBR09. YOU MUST USE SOMETHING MORE SPECIFIC.

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332	ALLOWED AMOUNT MUST BE EQUAL TO OR GREATER THAN PAID AMOUNT WHEN MEDICARE WAS PRIOR PAYER.	WHEN MEDICARE IS PRIOR PAYER, THE ALLOWED AMOUNT MUST BE EQUAL TO OR GREATER THAN THE PAID AMOUNT.
334	PRIMARY MAMMOGRAPHY CODE MUST BE BILLED ON SAME CLAIM	THE PRIMARY MAMMOGRAPHY CODE MUST BE FILED.
335	MEDICARE DEDUCTIBLE AMOUNT SUBMITTED EXCEEDS MEDICARE ANNUAL AMOUNT	THE DEDUCTIBLE AMOUNT SUBMITTED IS GREATER THAN THE ANNUAL MEDICARE AMOUNT.
336	BILLING NPI SUBMITTED IS NOT VALID FOR RENDERING SERVICES	THE BILLING NPI SUBMITTED IS VALID, BUT THE RENDERING/SERVICE FACILITY ADDRESS SUBMITTED IS NOT SET UP IN THE BLUE CROSS SYSTEM.
340	MEDICARE ALLOWED AMOUNTS EXCEEDS TOTAL SUBMITTED CHARGE	MEDICARE ALLOWED AMOUNT SUBMITTED IS GREATER THAN THE TOTAL CHARGE SUBMITTED.
342	SECONDARY CPLUS CLAIM WHERE MEDICARE WAS NOT PRIOR PAYER	SECONDARY CPLUS CLAIM WHERE MEDICARE WAS NOT PRIOR PAYER
347	CORRECTED CLAIM NOT ACCEPTED, ORIGINAL CLAIM NUMBER NOT FOUND ON THIS CONTRACT	THE ORIGINAL CLAIM NUMBER FILED IS NOT FOUND ON THIS CONTRACT.
351	CLAIM LEVEL LOCATION OF SERVICES RENDERED MUST BE A PHYSICAL ADDRESS	A PHYSICAL ADDRESS MUST BE SUBMITTED.
352	SERVICES RENDERED MUST BE PERFORMED AT A PHYSICAL LOCATION	A PHYSICAL ADDRESS MUST BE SUBMITTED.
353	RENDERING PROVIDER TAX ID NOT ON FILE	THE TAX ID SUBMITTED IS NOT ON FILE WITH BLUE CROSS.
354	CLAIM SFAC ADDRESS MUST BE MORE SPECIFIC (XXXXXXXXXXXXXXXXXX)	THE CLAIM SERVICE FACILITY ADDRESS MUST BE MORE SPECIFIC.

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355	BILLING ADDRESS MUST BE MORE SPECIFIC (XXXXXXXXXXXXXXXXXX)	THE CLAIM BILLING ADDRESS MUST BE MORE SPECIFIC.
356	FILE TWO CLAIMS - ONE PER CALENDER YEAR	FILE TWO CLAIMS - ONE PER CALENDER YEAR
357	PATIENT RELATIONSHIP CODE MUST BE VALID FOR ITS HOST CLAIMS.	PATIENT RELATIONSHIP CODE TO INSURED MUST BE PRESENT AND VALID ON CLAIM.
359	INVALID SUBMITTER ID FOR NPI NUMBER OR TAX ID	INVALID SUBMITTER ID FOR NPI NUMBER OR TAX ID
360	CLAIM IN PROCESSING	CLAIM IN PROCESSING
361	DUPLICATE CLAIM	DUPLICATE CLAIM
362	CONTRACT NOT FOUND	CONTRACT NOT FOUND
399	CLAIM CONTAINED LINE ERRORS (NO DISPLAY)	LOOK FOR 400 RANGE ERROR MESSAGE. THIS ERROR SHOULD NOT BE DISPLAYED.
400	DATE INVALID OR NOT NUMERIC	SUBMITTED DATE IS NOT IN THE CORRECT FORMAT (CCYYMMDD) OR IS NOT NUMERIC.
401	PROV LOCATION NOT SET UP FOR EMC / INVALID LI PROV (99999XXX)	LINE ITEM PROVIDER IS NOT LISTED ON THE BLUE CROSS PROVIDER MASTER FILE. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
402	SERVICES RENDERED AFTER PROVIDER INACTIVE	SERVICE DATE IS AFTER PROVIDER CANCEL DATE ON PROVIDER MASTER FILE.
403	FROM SERVICE DATE IS GREATER THAN THRU SERVICE DATE	THE SUBMITTED SERVICE FROM DATE IS GREATER THAN THE SUBMITTED SERVICE THRU DATE OR THE DATE IS IN AN INVALID FORMAT (CCYYMMDD).
404	FROM SERVICE DATE IS GREATER THAN DATE CLAIM RECEIVED	THE SUBMITTED FROM SERVICE DATE IS GREATER THAN THE RECEIPT DATE OF THE CLAIM. FUTURE DATED CLAIMS CANNOT BE SUBMITTED.

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405	THRU SERVICE DATE IS GREATER THAN DATE CLAIM RECEIVED	THE SUBMITTED THRU SERVICE DATE IS GREATER THAN THE RECEIPT DATE OF THE CLAIM. FUTURE DATED CLAIMS CANNOT BE SUBMITTED.
406	NUMBER OF SERVICES IS LESS THAN DAYS IN BILLING PERIOD	THE SUBMITTED NUMBER OF SERVICES IS LESS THAN THE NUMBER OF DAYS IN THE SUBMITTED BILLING PERIOD.
407	PLACE OF SERVICE IS BLANK	NO SERVICE LOCATION WAS FILED AT THE LINE LEVEL.
408	INVALID TO BILL CRNA SERVICES SEPARATELY	CANNOT BILL MODIFIERS WL OR WM ALONG WITH OTHER ANESTHESIA CHARGES.
409	SERVICE DATE OUTSIDE ADMISSION/DISCHARGE DATE	SERVICE FROM OR THRU DATE DOES NOT FALL WITHIN THE ADMISSION AND DISCHARGE DATES.
410	SPECIFIC AMBULANCE CODE NEEDED	A0999 NON-SPECIFIC HCPCS CODE SUBMITTED. MORE SPECIFIC HCPCS CODE NEEDED.
412	MORE SPECIFIC PROCEDURE CODE NEEDED (XXXXX)	IF PROCEDURE CODE ENDS WITH 99, RESUBMIT WITH MORE SPECIFIC PROCEDURE CODE.
413	NDC REQUIRED FOR THIS PROCEDURE CODE	FOR HOME HEALTH PROVIDERS, AN NDC NUMBER IS REQUIRED FOR PROCEDURE SUBMITTED.
414	PROC (XXXXX) INVALID FOR SEX	THE PROCEDURE CODE SUBMITTED IS NOT ALLOWED FOR THE SEX CODE SUBMITTED ON THE CLAIM. CHECK THE SEX CODE AND PROCEDURE DESCRIPTION FOR EXPLANATION. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
415	THE SAME PROVIDER CANNOT BILL AS BOTH SURGEON AND ASSISTANT SURGEON ON THE SAME CLAIM	THE SAME PROVIDER CANNOT BILL AS BOTH SURGEON AND ASSISTANT SURGEON ON THE SAME CLAIM.
416	FILE HARDCOPY WITH EXTRA DOCUMENT	PROCEDURE CODES 99082 AND M0916 MUST BE FILED HARD COPY WITH EXTRA DOCUMENTATION IN ORDER FOR PROCESSING TO OCCUR. FOR PROCEDURE CODES S9900, S9902, S9975 OR S9980 FILE HARD COPY WITH EXTRA DOCUMENTATION UNLESS THE SUBMITTER IS MEDICAID.

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417	INVALID PROCEDURE CODE (XXXXX)	PROCEDURE CODE IS NOT VALID FOR THE SERVICE DATE SUBMITTED. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
419	SUBMIT THRU NASCO PRE-PAID DRUG PROG	FOR NASCO GROUPS (17603, 37600, 38007, 38008, 38081, 38082), OR PREFIX WITH NCH AND IF THE PROCEDURE CODE IS 95135 THRU 95155, THEN THE CLAIM MUST BE FILED WITH NASCO AT: NASCO DEDICATED PROCESSING P.O. BOX 13427 BIRMINGHAM, AL 35202-3427
420	ANESTHESIA INFORMATION IS MISSING	ANESTHESIA UNITS WERE SUBMITTED FOR PROCEDURE CODE REQUIRING MINUTES.
421	MORE THAN ONE ANESTHESIA CHARGE FILED ON CLAIM	FOR ANESTHESIA PROCEDURE CODES, A CLAIM CANNOT CONTAIN MORE THAN ONE CHARGE FOR THE SAME PROVIDER. ANESTHESIA SERVICES MUST BE BILLED SEPARATELY IN ORDER TO ACCURATELY REFLECT TIME.
422	INVALID PLACE OF SERVICE FOR PROCEDURE	THE SUBMITTED PLACE OF SERVICE IS NOT VALID FOR THE SUBMITTED PROCEDURE CODE.
423	ZERO CHARGES BILLED ON LINE	ZERO CHARGE AMOUNTS CANNOT BE SUBMITTED.
424	NEGATIVE CHARGE SUBMITTED	NEGATIVE CHARGE AMOUNTS CANNOT BE SUBMITTED.
425	DIAG CODE (IS BLANK) INVALID / DIAG CODE (PTR(9), 9999) INVALID FOR SVC DATE MM/DD/YYYY	DIAGNOSIS CODE SUBMITTED CONTAINS “.”, SPACES OR ZEROES OR IS NOT A CURRENT VALID ICD-9 CODE. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
427	SERVICE PAST FILING LIMIT	IF THE YEAR OF THE SERVICE DATE IS MORE THAN 10 YEARS PRIOR TO THE CURRENT DATE, CONTACT CUSTOMER SERVICE FOR ASSISTANCE.
428	MODIFIER (XX) INVALID	MODIFIER SUBMITTED IS NOT A VALID MODIFIER.

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430	MEDICAID PAID AMOUNT MISSING OR INVALID	THE MEDICAID PAID AMOUNT IS MISSING OR INVALID. IF MEDICAID IS LISTED AS THE PRIMARY PAYER PAID THEN THE COORDINATION OF BENEFITS PAYER PAID AMOUNT MUST BE GREATER THAN ZERO.
431	MULTIPLE BILLING PROVIDERS NOT ALLOWED AT LINE LEVEL - REFILE AS SPLIT CLAIMS	MULTIPLE BILLING PROVIDERS ARE NOT ALLOWED AT THE LINE LEVEL. IF MORE THAN ONE PROVIDER IS PRESENT, THE CLAIM NEEDS TO BE SPLIT INTO ONE CLAIM PER PROVIDER BEING FILED.
432	PROCEDURE REQUIRES EITHER LT OR RT MODIFIER	FOR UROLOGY SPECIALTY PROVIDERS, PROCEDURE CODES 50590 OR 52353 MUST BE SUBMITTED WITH MODIFIERS 'LT' OR 'RT'.
435	DIAG CODE (99999) MORE SPECIFIC PRIMARY DIAGNOSIS CODE NEEDED	THE FIRST THREE DIGITS OF THE DIAGNOSIS CODE MUST BE NUMERIC (WITH THE EXCEPTION OF V CODES). THE PRIMARY DIAGNOSIS CODE MUST BE MORE SPECIFIC.
436	BCBSAL DOES NOT RECOGNIZE THIS NDC (XXXXXXXXXXXX)	THE NDC NUMBER SUBMITTED IS NOT A VALID NUMBER. ANY CHARACTERS WITHIN THE PARENTHESIS REFLECT WHAT WAS ACTUALLY SUBMITTED ON THE CLAIM.
437	RX NUMBER REQUIRED FOR THIS PROCEDURE CODE	FOR HOME HEALTH PROVIDERS, SUBMITTED PROCEDURE CODE REQUIRES A PRESCRIPTION NUMBER.
438	DIAG (XXXXX) REQ ACCID DATE / DIAG (XXXXX) REQ ACCID DATE AND/OR CONDITION INDICATOR (BLOCK 10)	AN ACCIDENT DATE IS REQUIRED FOR THE DIAGNOSIS THAT WAS FILED.
439	SERVICE FACILITY ADDRESS REQUIRED FOR FACILITY TYPE CODE (XX) SUBMITTED	SERVICE FACILITY LOCATION IS REQUIRED FOR ALL CLAIMS EXCEPT CLAIMS WITH PLACE OF SERVICE (11) OR (12).
440	CR1 SEGMENT REQUIRED FOR AMBULANCE CLAIMS	AMBULANCE CLAIMS REQUIRE COMPLETION OF THE 2400 LOOP CR1 SEGMENT.
441	AMBULANCE MODIFIER MISSING OR INVALID	AMBULANCE MODIFIER SUBMITTED IS EITHER INVALID OR MISSING.

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442	MODIFIER AA, AD, QK OR QY REQUIRED FOR ANESTHESIA	MODIFIER AA, AD, QK OR QY IS REQUIRED WHEN THE PROVIDER SPECIALTY IS ANESTHESIA.
443	INVALID MODIFIER FOR PORTABLE X-RAY	MODIFIER SUBMITTED IS NOT A VALID MODIFIER FOR PORTABLE X-RAY.
444	MODIFIER LC, LD, OR RC REQUIRED FOR CORONARY PROCEDURE	CORONARY PROCEDURES REQUIRE USE OF THE FOLLOWING MODIFIERS: LC, LD, OR, RC.
445	MODIFIER QX OR QZ REQUIRED FOR CRNA/ANESTHESIA ASSISTANT	CLAIMS FILED FOR CRNA OR ANESTHESIA ASSISTANT REQUIRES THE FOLLOWING MODIFIERS: QX, OR, QZ.
447	ADMISSION DATE REQUIRED	ADMISSION DATE IS REQUIRED FOR PLACE OF SERVICE CODES 21, 51, 61, 41, AND 42. ONLY 1 OCCURRENCE OF ADMISSION DATE IS VALID.
451	PROVIDER TAX ID REQUIRED WITH LINE RENDERING NPI (XXXXXXXXXXXX)	THE TAX ID IS REQUIRED WITH NPI.
452	ADDRESS/STREET ADDRESS/ZIP CODE DOES NOT MATCH BCBS FILE FOR LINE RENDERING NPI (XXXXXXXXXXXX)	THE PHYSICAL ADDRESS OF THE PROVIDER DOES NOT MATCH WHAT IS ON FILE WITH BLUE CROSS.
455	LINE LEVEL NPI NOT ON FILE AT BLUE CROSS. PLEASE CONTACT PROVIDER DATA WITH NPI INFORMATION.	THE NPI FILED AT THE LINE LEVEL IS NOT ON FILE WITH BLUE CROSS. CONTACT PROVIDER DATA TO HAVE THIS UPDATED AT 205 220-7528.
459	FILE WITH THE NDC OF THE MAJOR COMPONENT IN THE COMPOUND DRUG	COMPOUND DRUGS SHOULD BE FILED USING THE NDC OF THE MAJOR COMPONENT.
460	DOSAGE INFORMATION IS REQUIRED IN THE NOTE SEGMENT FOR THIS PROCEDURE CODE	CERTAIN DRUGS REQUIRE DOSAGE INFORMATION. THIS SHOULD BE SUBMITTED IN THE 2400 LOOP NTE SEGMENT.

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461	LINE LEVEL OF LOCATION OF SERVICES RENDERED MUST BE A PHYSICAL ADDRESS	A PHYSICAL ADDRESS MUST BE SUBMITTED.
462	RENDERING NPI (XXXXXXXXXX) IS NOT VALID FOR BILLING NPI (XXXXXXXXXX)	THE NPI FOR THE RENDERING PROVIDER IS NOT VALID FOR THE BILLING NPI.
463	LINE SFAC ADDRESS MUST BE MORE SPECIFIC (XXXXXXXXXXXXXXXXXX)	THE LINE SERVICE FACILITY ADDRESS MUST BE MORE SPECIFIC.
464	MULTIPLE RESULTS FOR THE SAME TEST ARE INVALID	MULTIPLE RESULTS FOR THE SAME TEST ARE INVALID
465	HEMOGLOBIN/HEMATOCRIT LEVELS REQUIRED WITH PROCEDURE CODE (XXXXX)	HEMOGLOBIN/HEMATOCRIT LEVELS REQUIRED WITH PROCEDURE CODE (XXXXX)
466	TEST RESULT MEASUREMENT INVALID	TEST RESULT MEASUREMENT INVALID
888	INSTREAM REJECTION	LEVEL 1 AND LEVEL 2 COMPLIANCE ERRORS DETECTED BY OUR TRANSLATOR. PLEASE CONTACT YOUR VENDOR FOR SUPPORT.
998	BATCH REJECTED - DUPLICATE BATCH	THIS BATCH IS A DUPLICATE OF A BATCH PREVIOUSLY FILED.
999	BATCH ACCEPTED - NO DUPLICATE FOUND	THIS BATCH IS A DUPLICATE OF A BATCH PREVIOUSLY FILED.