AmeriHealth

Claims Resolution Matrix — Professional

This Claims Resolution Matrix is to be used as a reference tool to troubleshoot professional claims that have been submitted electronically (i.e., submitted via 837P transaction) and rejected. Refer to the Code Definitions document for detailed information about category, entity, and claim status codes.

Note: The Claim Status Codes you receive on your rejection may not be in the same order as they appear below in the primary, secondary, and tertiary status columns. Please be sure to search all columns for the applicable Claim Status Code. For example, on your rejection, you may have received Claim Status Codes 128 and 562; however, on the 277CA you may see these Claim Status Codes in the order of 562 and 128.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
1	A7	26	85	A7	562	85	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.NM109	The Billing Provider National Provider Identifier (NPI) submitted on the claim is invalid. Resubmit the claim using a valid Billing Provider NPI.
2	A7	33	IL	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.NM109	The member ID number submitted was not valid. Submit the member ID number as it appears on the member's ID card — without spaces, hyphens, dashes, or other special characters.
3	A7	116	PR	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010BB.NM109	The payer code (Payer Name Identification Code — NM109) submitted on the claim is not valid for AmeriHealth. Resubmit the claim with the appropriate NAIC code applicable to the member's product on the claim. Review the payer ID grids for this information at www.amerihealth.com/edi. *Note:* If the provider/vendor is submitting the claims through Emdeon, the provider/vendor should use the Emdeon payer codes, which are also listed on the payer ID grids. Emdeon will convert the payer codes to our NAIC codes.
5	A7	124	77	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2310C.NM109	The provider submitted an ambulance claim with a Service Facility instead of the Ambulance Pick-Up and Drop-Off Loop. Correct and resubmit the claim.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
6	A8	128	85	A8	562	–	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.REF02	The Billing Provider ID does not match the Billing Provider Tax ID Number (TIN) submitted on the claim. Resubmit the claim using a Billing Provider ID that matches the TIN.
7	A6	145	85	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2000A.PRV03	The Billing Provider Taxonomy Code is required, along with the NPI, in order to find an exact provider match. Resubmit the claim with the Billing Provider Taxonomy Code.
8a	A7	145	85	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2000A.PRV03	The Taxonomy Code submitted for the Billing Provider is not a valid Taxonomy Code. Resubmit the claim with a valid Taxonomy Code.
8b	A7	145	82	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2310B.PRV03	The Taxonomy Code submitted for the Billing Provider is not a valid Taxonomy Code. Resubmit the claim with a valid Taxonomy Code.
9	A3	247	–	–	–	–	–	–	–	A8	145	85 on 145	A8	249	–	A8	454	–	2300.CLM05-1 or SV107, 2400.SV101	An independent laboratory submitted diagnostic pathology services on a claim with one of the following Places of Service: 03, 06, 08, 09, 15, 16, 26, 50, 54, 60, or 99. An independent laboratory is only allowed to submit with Place of Service 81. Resubmit the claim.
15	A6	156	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2000B.SBR02	A claim was received where the Relationship Code was missing. Resubmit the claim with the appropriate Relationship Code in the appropriate loop (either Subscriber Loop or Patient Loop).

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	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
16	A7	156	QC	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2000C.PAT02	A claim was received where the Relationship Code was reported in both the Subscriber Loop and the Patient Loop. Resubmit the claim with the Relationship Code in *either* the Subscriber Loop *or* the Patient Loop.
17	A6	158	QC or IL	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.DMG02 or 2010CA.MG02	A claim was received with no date of birth. Resubmit the claim with the member's date of birth in either the Subscriber Loop or the Patient Loop.
18	A7	158	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.DMG02 or 2010CA.MG02	The provider submitted an invalid date. The year was on or before 1850. Resubmit the claim using the appropriate date.
19a	A8	187	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.DMG02 or 2010CA. DMG02 vs. 2300-DTP02	The submitted member's Date of Birth is prior to the Date of Service. Resubmit the claim with the appropriate Date of Birth for the member.
19b	–	–	–	–	–	–	–	–	–	A8	158	QC or IL	A8	187	–	–	–	–	2010BA.DMG02 or 2010CA. DMG02 or 2400-DTP03	The submitted member's Date of Birth is prior to the Date of Service. Resubmit the claim with the appropriate Date of Birth for the member.
20	A8	158	QC - patient IL- sub	A8	510	QC - patient IL- sub	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.DMG02 2010CA.DMG02 vs. EDI timestamp	The provider submitted an invalid date. The date was after the GS04 (file creation date). Resubmit the claim using the appropriate date.
21	A6	162	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.REF02	The Original Reference Number is required when CLM05-3 equals 7 or 8 (indicates adjustment request). Resubmit the claim with the Original Reference Number.

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Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
22	A6	164	IL	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.NM109	The claim was submitted without a member ID number. Resubmit the claim with the member ID number as it appears on the member's ID card.
23	A7	171	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2320.SBR09	A claim was submitted with multiple Medicare or Medicaid Claim Filing Indicators. Resubmit the claim so that there is no more than one Medicare Claim Filing Indicator or Medicaid Claim Filing Indicator.
26	A3	247	–	–	–	–	–	–	–	A7	187	–	–	–	–	–	–	–	2400.DTP03	A claim was submitted with either a future Date of Service at the service line-level date or a Date of Service before 1900. Resubmit the claim with a valid line-level Date of Service.
27	A3	247	–	–	–	–	–	–	–	A7	187	–	–	–	–	–	–	–	2400.DTP03 when 2400.DTP01 = 472	The provider submitted a claim with the End Date prior to the Begin Date of Service. Correct and resubmit the claim.
28	A3	247	–	–	–	–	–	–	–	A7	187	–	–	–	–	–	–	–	2400.SV101-2 vs. 2400.DTP03	The provider submitted a date range on prolonged detention care procedures (G0240, G0241, 99289 – 99292, 99466, and 99467). Resubmit this claim with one Date of Service.
30	A8	187	–	A8	262	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.HI01-2 when 2300.HI01.1 = BP or 2300.HI02-2 when 2300.HI01.2 = BO or	The provider submitted a claim with an invalid anesthesia-related Procedure Code. Correct and resubmit the claim.

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	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
31	A8	187	–	A8	397	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 431 (Onset of Current Symptoms or Illness) vs. 2400.DTP03 when 2400.DTP01 = 472 (Service Line Date)	If the Onset of the Symptom Date is reported on the claim, the Service Line Date cannot be before the Onset of the Symptom Date. Correct and resubmit the claim.
133	A8	187		A8	718														2400.DTP03	The claim/service was not submitted within the required time frame (timely filing).
32	A3	247	–	–	–	–	–	–	–	A8	187	–	A8	453	–	–	–	–	2400.SV101-3	A claim was submitted with a Procedure Code Modifier that is either not valid for the Date of Service or is not a national value. Resubmit the claim with a valid Procedure Code Modifier.
33	A3	247	–	–	–	–	–	–	–	A8	187	–	A8	454	–	–	–	–	2400.SV101-2	The Procedure Code submitted on the claim was invalid. Resubmit the claim with a valid Procedure Code.
35	A3	247	–	–	–	–	–	–	–	A8	187	–	A8	510	–	–	–	–	2400.DTP03 vs. EDI timestamp	A claim was submitted with future Dates of Service (dates greater than the Original Claim Receipt Date). Resubmit the claim with valid Dates of Service.

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	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
36	A3	247	–	–	–	–	–	–	–	A8	187	–	A8	675	–	–	–	–	2300.DTP03 when 2300.DTP01 = 435 (Admission) or 096 (Discharge) vs. 2400.DTP03 when 2400.DTP01 = 472 (Service Line Date)	If the Onset of the Symptom Date is reported on the claim, the Begin Date and End Date cannot be before the Onset of the Symptom Date. Correct and resubmit the claim.
42	–	–	–	A7	189	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 with 435 qualifier	A claim was submitted with an Admission Date that is before 1900. Resubmit the claim with a valid Admission Date.
44	A8	189	–	A8	190	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 435 (Admission) or 096 (Discharge)	The Admission Date cannot be greater than 1 year prior to the Discharge Date when one of the following Places of Service is submitted on the claim: 04, 11, 12, 13, 14, 31 – 34, 49, 53, 71, or 72. Correct and resubmit the claim.
45	A8	189	–	A8	190	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 435 (Admission) or 096 (Discharge)	The Discharge Date is prior to the Admission Date for an inpatient or skilled nursing facility (SNF) claim with one of the following Places of Service reported: 21, 31, 51, 55, or 61. Correct and resubmit the claim.
46	A8	189	–	A8	249	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 435	The Admission Date was not submitted on the claim but was expected for newborn, intensive care, inpatient, SNF, and psychiatric claims with one of the following Places of Service reported: 21, 31, 51, 55, or 61. Correct and resubmit the claim.

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	Claims Level Loop 2200D									Line Level Loop 2220D										
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Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
47	A8	189	–	A8	510	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 with 435 qualifier vs. EDI timestamp	A claim was submitted with an Admission Date that is greater than the Original Claim Receipt Date. Resubmit the claim with a valid Admission Date.
48	–	–	–	A7	190	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 096 (Discharge)	The provider submitted an invalid date. The date is before 1900. Resubmit the claim using the appropriate date.
49	A8	190	–	A8	510	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 096 (Discharge)	The provider submitted an invalid date. The date is after the GS04. Resubmit the claim using the appropriate date.
50	–	–	–	A6	195	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 314 (Disability)/ DTP02 = RD8	The provider submitted the Disability Date with an incorrect date format. Resubmit the claim using the appropriate date format.
51	–	–	–	A7	195	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.DTP03 when 2300.DTP01 = 360 (Initial Disability Period Start) or 361 (Initial Disability Period End)/ DTP02 = D8	The provider submitted the initial Disability Period Start and End Date with an incorrect date format. Resubmit the claim using the appropriate date format.
66a	A7	249	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.CLM05-1	The Place of Service Code on the claim is invalid. Resubmit the claim with a valid Place of Service Code.
66b	A3	247	–	–	–	–	–	–	–	A7	249	–	–	–	–	–	–	–	2400.SV105	The Place of Service Code on the claim is invalid. Resubmit the claim with a valid Place of Service Code.

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Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	837P Loop/Data Element	Error Resolutions 837P
67	A3	247	–	–	–	–	–	–	–	A8	249	–	A8	454	–	–	–	–	2300.CLM05-1 or 2400.SV105 vs. 2400SV101-2	The Place of Service is not valid for the Procedure Code submitted on the claim. Correct and resubmit the claim.
68	A3	247	–	–	–	–	–	–	–	A8	249	–	A8	675	–	–	–	–	2300-CLM05-1 2400.SV105 vs. 2400.DTP03	The line-level Begin and/or End Dates of Service are NOT within the Admission/Discharge Dates when the Place of Service is 13, 21, 31, 32, 33, 51, 55, or 61. Correct and resubmit the claim.
69	A3	247	–	–	–	–	–	–	–	A7	251	–	–	–	–	–	–	–	2400.SV104	The minutes reported on an anesthesia claim exceed 9,999 minutes. Resubmit the claim with minutes equal to or less than 9,999.
70	A3	247	–	–	–	–	–	–	–	A8	255	–	A8	187	–	A8	404	–	2300.HI01-2 with qualifiers: BK or ABK BF or ABF	The claim was submitted with an invalid Diagnosis Code or not the highest level of specificity (this includes Principal and Other codes). Resubmit the claim with a valid Diagnosis Code that is to the highest level of specificity.
72	A7	262	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.HI01-2 when HI01-1 = BP and 2300. HI02-2 – HI08-2 when HI02-1 – HI08-1 = BO vs.2400-DTP03 when DTP01 = 472	The anesthesia Procedure Code submitted on the claim was not effective for the Service Line Date on the claim. Resubmit the claim with a valid Procedure Code that is within the Effective and Termination Date of the Procedure Code.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
73	A3	247	–	–	–	–	–	–	–	A8	262	–	A8	473	–	–	–	–	2300.HI01-2 when HI01-1 = BP and 2300. HI02-2 – HI08-2 when HI02-1 – HI08-1 = BO vs. 2010BA or 2010CA DMG02	The anesthesia-related Procedure Code submitted on the claim is not applicable to the patient's age. Resubmit the claim with the appropriate anesthesia-related Procedure Code.
74	A8	454	–	A8	751	–	–	–	–	–	–	–	–	–	–	–	–	–	2310E.N403	The claim was submitted without an Ambulance Pick-Up Address. Resubmit the claim with Ambulance Pick-Up and Drop-Off Addresses.
75	A8	454	–	A8	740	–	–	–	–	–	–	–	–	–	–	–	–	–	2310F.N403	The claim was submitted without an Ambulance Drop-Off Address. Resubmit the claim with Ambulance Pick-Up and Drop-Off Addresses.
76	A8	286	–	A8	554	–	–	–	–	–	–	–	–	–	–	–	–	–	If 2320 SBR09 = MA or MB and 2320 MOA03-7 = MA18 or N89, check 2330B vs. EDI date stamp	A Secondary to Medicare claim was submitted less than 30 days from the submission to Medicare. Resubmit the claim no fewer than 30 days after the submission to Medicare.
78	A3	247	–	–	–	–	–	–	–	A6	306	–	–	–	–	–	–	–	2400.SV101-7	A claim was submitted with an NOC HCPCS/CPT® code and no Procedure Description. Resubmit the claim with a Procedure Description for the NOC HCPCS/CPT and Revenue Codes.
79	A3	247	–	–	–	–	–	–	–	A3	400	–	–	–	–	–	–	–	2300.CLM02 vs. 2400.SV102	A claim was submitted where the sum of all the line charges does not match the claim's Total Charge Amount. Resubmit the claim with the appropriate claim charges.

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Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	837P Loop/Data Element	Error Resolutions 837P
80	A3	247	–	–	–	–	–	–	–	A6	453	–	–	–	–	–	–	–	2400.SV101-(3, 4, 5, 6)	The anesthesia Certification Modifier is expected when an anesthesia Procedure Code is submitted on the claim. Resubmit the claim with the appropriate anesthesia Certification Modifier.
81	A3	247	–	–	–	–	–	–	–	A8	453	–	A8	454	–	–	–	–	2400.SV101-(3, 4, 5, 6)	The provider submitted the claim with an anesthesia Certification Modifier with a non-anesthesia Procedure Code. Correct and resubmit the claim.
82	A3	247	–	–	–	–	–	–	–	A7	454	–	–	–	–	–	–	–	2400.SV101-1	The claim was submitted with a Procedure Code Qualifier (ER, IV, or WK) that is not mandated by HIPAA. Resubmit the claim with the appropriate Procedure Code Qualifier.
88	A7	460	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.HI01-2 when HI01-1 = BG	The Condition Code submitted on the claim was invalid. Resubmit the claim with a valid Condition Code.
92	A3	247	–	–	–	–	–	–	–	A3	475	–	–	–	–	–	–	–	2400.SV101-2 vs. 2010BA. DMG02 or 2010CA.DMG02	The Procedure Code submitted on the claim is not applicable to the patient's age. Resubmit the claim with the appropriate Procedure Code.
93	A3	247	–	–	–	–	–	–	–	A3	476	–	–	–	–	–	–	–	2400.SV103 = MJ (minutes)	The provider submitted an anesthesia Procedure Code with units instead of minutes. Resubmit the claim with minutes (2400.SV103 must equal MJ).
94	A3	247	–	–	–	–	–	–	–	A3	476	–	–	–	–	–	–	–	2400.SV103 = UN (unit)	The provider submitted a non-anesthesia Procedure Code with minutes instead of units. Resubmit the claim with units (2400.SV103 must equal UN).

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Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
95	A3	247	–	–	–	–	–	–	–	A7	477	–	–	–	–	–	–	–	2400.SV107	The Diagnosis Code Pointer submitted on the claim is greater than the number of Diagnosis Codes reported. Correct and resubmit the claim.
132	A8	255	–	A8	508	–	A8	700	–	A7	477	–	–	–	–	–	–	–	2300.HI01-1 thru HI01-12 with qualifiers: BK or ABK BF or ABF	The claim was submitted with a mix of ICD-9 and ICD-10 diagnosis qualifiers/codes. All diagnosis qualifiers/codes on the claim must be either ICD-9 or ICD-10. Resubmit the claim with only one ICD version.
96	A7	479	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2330B.NM109 vs. 2430-SVD01	A claim was submitted where the claim-level Other Payer ID and the line-level Other Payer ID do not match. Resubmit the claim with the same Other Payer ID at both the claim level and line level.
97	A6	480	PR	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2320.SBR09	A multi-payer claim was submitted where the Claim Filing Indicator is missing for the Other Payer. Resubmit the claim with the Other Payer Claim Filing Indicator.
101	A8	496	41	A8	562	85	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.NM109 vs. GS02	A claim was submitted with a Billing Provider NPI that is not set up for the trading partner. Ensure that the Billing Provider NPI is registered with trading partner.
102	A6	500	85 - billing 77 - svc facility	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.N403 or 2310C.N403	A claim was received where the Billing Provider and/or the Service Facility Provider's ZIP code was not 9 positions in length. Resubmit the claim with valid provider ZIP codes.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
103	A7	500	85 - billing 77 - svc facility	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.N403 or 2310C.N403	A claim was received where the last 4 positions of the Billing Provider and/or the Service Facility Provider's ZIP code were zeros or spaces. Resubmit the claim with valid provider ZIP codes.
104	A6	503	85 - billing 77 - svc facility	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.N301 or 2310C.N301	A claim was received where the Billing Provider and/or the Service Facility Provider's address was a P.O. Box or Lockbox. Resubmit the claim with a valid street address for the Billing Provider and/or Service Facility Provider.
106a	A7	521	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2320-CAS02 Several CAS elements, CAS02 is first occurrence	A professional claim was submitted with an invalid Claim Adjustment Reason Code. Resubmit claim with a valid Claim Adjustment Reason Code.
106b	A3	247	–	–	–	–	–	–	–	A7	521	–	–	–	–	–	–	–	2430-CAS02 Several CAS elements, CAS02 is first occurrence	A professional claim was submitted with an invalid Claim Adjustment Reason Code. Resubmit claim with a valid Claim Adjustment Reason Code.
107	A6	562	DN	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2310A.NM109 when CLM05-1 or SV105 = 81	The Referring Provider NPI was not submitted on the claim. Resubmit the claim with a valid Referring Provider NPI.
108	A7	562	85 - billing 82 (837P) - rendering 77 - svc facility	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2010AA.NM109 or 2310B.NM109 or 2310C.NM109	The Billing Provider NPI or the Rendering Provider NPI submitted on the claim is invalid. Resubmit the claim using a valid Billing Provider NPI or Rendering Provider NPI.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
109	A8	633	–	A8	727	–	–	–	–	–	–	–	–	–	–	–	–	–	2300-CLM11-1/2 vs. 2300.DTP03 when 2300.DTP01 = 439 (Accident)	The Auto Accident Date was expected when related cause code equals AA (auto accident), but it was not submitted on the claim. Resubmit the claim with the Auto Accident Date.
110	A8	633	–	A8	728	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.CLM11-1/2 vs. 2300-CLM11-4	The Auto Accident State was expected when related cause code equals AA (auto accident), but it was not submitted on the claim. Resubmit the claim with the Auto Accident State.
111	A7	672	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2430.SVD02 + 2430.CAS03	A claim was submitted where the line-level Other Party Liability/ Coordination of Benefits (OPL/COB) amounts (Claim Adjustment Amounts and Paid Amounts) did not equal the line-level charge reported. Resubmit the claim with the OPL/COB information in balance.
112	A7	672	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2320.CAS03 + 2320.AMT02 = 2300.CLM02	A claim was submitted where the sum of all line-level OPL/COB amounts (Claim Adjustment Amounts and Paid Amounts) did not equal the total claim-level charges reported. Resubmit the claim with the OPL/COB information in balance.
113	A3	247	–	–	–	–	–	–	–	A6	672	–	–	–	–	–	–	–	2320.CAS03 + 2430.SVD02 = 2300.CLM02	The claim was submitted with a claim-level Paid Amount that does not equal the Claim Level Adjustment Amount. Resubmit the claim with the correct amount.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
125	A3	247	–	–	–	–	–	–	–	A8	218	–	A8	454	–	–	–	–	2400.SV101-2 vs. 2410.LIN03	The claim was submitted without the NDC Code. If an NOC CPT/ HCPCS Drug Procedure Code is submitted on the claim, the NDC Code is required in addition to whatever is sent in the description field. Resubmit the claim with a valid NDC Code.
126	A3	247	–	–	–	–	–	–	–	A6	218	–	–	–	–	–	–	–	2400.SV101-2 vs. 2410.LIN03	The claim was submitted without the NDC Code. If an NOC CPT/ HCPCS Drug Procedure Code is submitted on the claim, the NDC Code is required in addition to whatever is sent in the description field. Resubmit the claim with a valid NDC Code.
126a	A3	247	–	–	–	–	–	–	–	A7	218	–	–	–	–	–	–	–	2410.LIN03	The claim was submitted with an invalid NDC Code.
127	A8	33	IL	A8	116	PR	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.NM109	The member ID number submitted on the claim was not valid. Resubmit the claim with a valid member ID number as it appears on the member's ID card.
128	A8	33	IL	A8	116	PR	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.NM109	The member ID number submitted on the claim was not valid. Resubmit the claim with a valid member ID number as it appears on the member's ID card.
129	A8	33	IL	A8	116	PR	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.NM109	AmeriHealth Caritas claims must be submitted to AmeriHealth as secondary, and prior payments from the prior carrier must exist on the claim.

	277 Claim Acknowledgments Details																		Claim Resolution Instructions	
	Claims Level Loop 2200D									Line Level Loop 2220D										
	Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			Primary Status 277CA Elements			Secondary Status 277CA Elements			Tertiary Status 277CA Elements			837P Loop/Data Element	Error Resolutions 837P
Edit #	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3	STC01-1	STC01-2	STC01-3	STC10-1	STC10-2	STC10-3	STC11-1	STC11-2	STC11-3		
130	A8	33	IL	A8	116	PR	–	–	–	–	–	–	–	–	–	–	–	–	2010BA.NM109 GS03	The claim was submitted with Payer Code 54763 for a member who is an AmeriHealth member. Resubmit the claim with the correct Payer Code.
131	A3	771	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	If 2320 SBR09 = MA or MB and 2320 MOA03-7 = MA18 or N89, check 2330B vs. EDI date stamp	A Secondary to Medicare claim was submitted fewer than 30 days from the submission to Medicare. Resubmit the claim no fewer than 30 days after the submission to Medicare.
134	A7	255	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2300.HI01-2 - HI012-2 when HI01-1 = ABK and HI02-1 - HI012-1 = ABF	The claim was submitted with the same diagnosis code more than once. Resubmit the claim with the diagnosis code submitted only once.