

Denial Reason (CARC)	Description
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
32	Our records indicate the patient is not an eligible dependent.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
69	Day outlier amount.
78	Non-Covered days/Room charge adjustment.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
100	PAYMENT MADE TO PATIENT/INSURED/RESPONSIBLE PARTY/EMPLOYER.
119	Benefit maximum for this time period or occurrence has been reached.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
149	Lifetime benefit maximum has been reached for this service/benefit category.

Denial Reason (CARC)	Description
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
160	Injury/illness was the result of an activity that is a benefit exclusion.
166	THESE SERVICES WERE SUBMITTED AFTER THIS PAYERS RESPONSIBILITY FOR PROCESSING CLAIMS UNDER THIS PLAN ENDED.
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
172	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
177	Patient has not met the required eligibility requirements.
178	Patient has not met the required spend down requirements.
180	Patient has not met the required residency requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
191	CLAIM DENIED BECAUSE THIS IS NOT A WORK RELATED INJURY/ILLNESS AND THUS NOT THE LIABILITY OF THE WORKERS' COMPENSATION CARRIER.
200	Expenses incurred during lapse in coverage.
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.).
202	Non-covered personal comfort or convenience services.
204	This service/equipment/drug is not covered under the patient's current benefit plan.
211	National Drug Codes (NDC) not eligible for rebate, are not covered.

Denial Reason (CARC)	Description
214	Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
215	Based on subrogation of a third party settlement.
219	Based on extent of injury.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
246	This non-payable code is for required reporting only.
256	Service not payable per managed care contract.
273	Coverage/program guidelines were exceeded.
274	Fee/Service not payable per patient Care Coordination arrangement.
276	Services denied by the prior payer(s) are not covered by this payer.
289	Services considered under the dental and medical plans, benefits not available.
299	The billing provider is not eligible to receive payment for the service billed.
A1	Claim/Service denied.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
B1	Non-covered visits.
B1	NON-COVERED VISITS.
B14	Only one visit or consultation per physician per day is covered.
B4	Late filing penalty.
P2	Not a work related injury/illness and thus not the liability Not a work related injury/illness and thus not the liability of the workers' compensation carrier Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.