# **Paper Claim - Reject Codes**

[Reject Codes](#_Toc201298754)

[Related Documents](#_Toc201298755)

**Description:** Reject codes related to paper claims, and related information on how to resolve.

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| **R****eject Codes** |

When a Paper Claim (reimbursement request) is unable to process a claim in the system, a manual reject letter will be sent to the member informing them of the reason. This can occur for various reasons, such as missing information, eligibility not on file, etcetera and results in copies of the claim documents being returned to the member. The original documents are scanned into the system and will not be returned to the member.

**Note:** If the member did not receive a rejection letter, refer to [Compass - Identifying Paper Claims (050034)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=c281dde6-a86e-451a-8828-9f2b98c17bb9).

Below is a list of the potential reject reason messages that may be shown on the member letter. If a member calls about one of these letters, ask them to provide you with the message shown on the letter (or review the rejection code listed in PeopleSafe/Compass), then use it as a guide to assist you with researching the issue.

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| **Code** | **Description** |
| **A1** | Supplemental message of Prescriber ID is “State Excluded.”  Refer to [Federal and State Excluded Prescriber Customer Care Talk Track (068770)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3eb01d80-5d21-4e52-a638-8b7d5ca61d58). |
| **1** | **Member ID#** - According to our records, this plan member is not eligible for prescription benefits. Please ensure that the plan member ID number and date of birth that you provided on the claim were correct. Refer to [Compass - Member Search (050037)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=44e71d7a-1b1c-4931-9089-d4161a72d114). |
| **2** | We cannot provide benefits for these charges because the prescription was filled before the plan member's coverage was effective or after it was terminated. If you were covered at this time, please call the toll-free number on your benefit ID card. |
| **3** | Our PBM is not contracted to process claims for the prescription benefit plan. |
| **4** | The prescription benefit plan has no provision for the attached claims. |
| **6** | The claim submitted was determined to be for medical services. |
| **7** | The prescription benefit plan has no provision for Coordination of Benefits. |
| **8** | International claims are not a covered benefit selected by your plan sponsor. This cost may be covered under your major medical benefit. |
| **9** | The prescription benefit plan has no provision for Assignment of Benefits. |
| **10** | This claim has previously been submitted and processed. |
| **11** | To process your Coordination of Benefits Claim, we need a copy of the Medicare Explanation of Benefits (EOB) or denial letter from your other plan sponsor. The Medicare EOB must contain the Total Charge, Insurance Paid Amount and Plan Member’s Responsibility. |
| **12** | To process your Coordination of Benefits Claim, we need a copy of the Explanation of Benefits (EOB) or denial letter from the Primary plan sponsor. The EOB must contain the Total Charge, Insurance Paid Amount and Plan Member's Responsibility. |
| **14** | To process your claim for benefits, we require a **UB-04** (Universal Billing Form) for claims from the VA facility. |
| **15** | Please provide a clarification of charges since the claim contains multiple credits. Please request an original receipt or statement from the pharmacy where your prescription was filled. |
| **16** | Your claim was submitted beyond the filing deadline. |
| **18** | Your coverage does not provide benefits for medicine billed in advance. Please submit your claim after you receive the medicine or if the date is incorrect, correct the date, and resubmit it for processing. |
| **19** | Claims submitted by a plan member are not allowed, based on the benefits selected by your plan sponsor. |
| **20** | Additional information needed. Please refer to circled or noted information on enclosure(s). |
| **21** | **Prescription#** - We need the prescription number before we can process your claim. This information can be obtained from your receipts, your prescription label or from your pharmacy. |
| **22** | **Original Receipts** - The Pharmacy / Dispensing Facility receipt provided as proof of purchase must contain the following information: Patient name, prescription number, date filled, dispensing pharmacy name and address, drug name, National Drug code (NDC), strength / form, quantity, ingredient cost, gross amount due, days' supply and price. If you provided a receipt, you may be missing one or more of the items required. Please contact your Pharmacy / Dispensing Facility to obtain the requested information. |
| **24** | **Date of Fill** - We need the complete date the prescription was filled to process your claim. Please resubmit with the month/date/year your prescription was filled. |
| **25** | **Quantity** - The quantity of this medicine is invalid or missing and is required to process your claim. Please indicate the quantity of tablets, milliliters, or grams dispensed. This information can be obtained from your pharmacy. |
| **26** | **Days' Supply** - The days' supply of this medicine is invalid or missing and is required to process your claim. Please indicate the number of days for which the medication was prescribed. |
| **27** | **NPI** or **NCPDP** or **NABP#** - After researching the pharmacy information provided, we are unable to locate an active NCPDP or NPI number to process the claim. Please contact the Pharmacy where the prescription was filled to obtain the active NCPDP or NPI number. |
| **30** | Your plan sponsor requires a signed and dated claim form with each claim submitted. Once you obtain a claim form, please sign and date it and resubmit it for consideration under your benefit plan. |
| **31** | We are unable to read your claim due to damaged or illegible information. Please resubmit a legible copy of your claim for processing. |
| **32** | **NDC#** - After researching the drug information provided, we are unable to obtain an NDC number to process the claim. If this is a compound medicine, please provide a list of the ingredients and the NDC numbers. Please contact the Pharmacy where the prescription was filled to obtain this information. |
| **35** | Provide the name of the country and currency in which the prescription(s) was filled. |
| **36** | We are unable to translate the United States equivalent of this medicine purchased outside of the country. Please provide the United States equivalent of this medicine. |
| **37** | Attached claim(s) have been processed by another insurance carrier. |
| **38** | To provide the correct reimbursement, please submit an overpayment or recovery letter from the other insurance, which includes the co-pay amount(s) paid by the other insurance. |
| **41** | According to the plan, all prescription drugs must be submitted directly by the plan member. |
| **42** | Claims submitted by a plan member are not allowed, based on the benefits selected by your Benefits carrier. |
| **43** | The Prescription Benefit Plan has no provision for Workman's Compensation claims. |
| **44** | Drugs dispensed by a physician are not a covered pharmacy benefit. |
| **45** | Allergens are not a covered item selected by your plan sponsor. This cost may be covered under your major medical benefit. If you have any questions, please contact your benefits coordinator. |
| **46** | This plan is a discount drug program only; therefore, no reimbursement was issued. |
| **48** | The pharmacy where your prescription was filled is outside the network of pharmacies chosen by your plan. |
| **50** | For a compound medication please provide a receipt(s) or itemized printout with each ingredient in the compound. Please provide the NDC number, ingredient name, metric quantity dispensed and ingredient cost for each individual ingredient in the compound. |
| **51** | Please provide valid NDC numbers for all ingredients in the compound medication. |
| **52** | Please provide the metric quantity dispensed for each ingredient in the compound medication. |
| **53** | Please provide the ingredient cost for each individual ingredient in the compound medication. |
| **54** | Please provide a receipt(s) or itemized printout from the pharmacy to include the total quantity and total price paid for the compound medication. |
| **59** | To assist you in providing the information needed to process your claim(s) we have included a form for you or your pharmacist to complete. (This reason code will need to be on all rejected compound claims). |
| **61** | Refill too Soon - Your prescription was filled prior to the allowable refill date according to your plan. If you have any questions, please call the toll-free number on your benefit ID card. |
| **66** | The prescription benefit plan requires appeals to be submitted to the Coventry Appeals Office. |
| **67** | The claim has been denied. The prescription benefit plan requires the prescription ID card to be presented at the pharmacy, except in emergency situations. |
| **68** | Health Net denied payment based on the information provided. Please contact your plan for additional instructions. |
| **69** | Attached circled claim(s) have been rejected. Claim(s) have been processed by another insurance when Health Net is primary. |
| **70** | Attached circled claim(s) have been rejected. Health Net requires prior authorization. Refer to [Compass - Rejection Codes and Resolutions (Reject 01 – Reject ZN) (067649)](https://thesource.cvshealth.com/nuxeo/nxfile/default/104c3318-95ba-42e2-bd05-17877b0a8045/ncf:generated_pdf/GEN%2067649%20Compass%20-%20Rej%20Codes%20and%20Resolutions%20%20pulled%2009262024.docx.html?changeToken=25201-0&inline=true#_Toc165969247). |
| **71** | Attached circled claim(s) have been rejected. To provide correct reimbursement, please submit the information to the proper Medical Insurance Carrier. |
| **72** | Attached circled claim(s) have been rejected. To provide correct reimbursement, please submit the information requested above on an original Rx receipt(s) or Pharmacy Print-Out. |
| **73** | Attached circled claim(s) have been rejected. No U.S. Equivalent and/or not FDA approved. |
| **74** | You submitted a claim with multiple vaccines, but only one vaccine administration fee. An administration fee must be submitted for each vaccine listed on your claim. Please resubmit your claim clearly indicating the **drug name** and **drug number (NDC #)** for each vaccine and identify an administration fee for each vaccine listed on the claim. Feel free to attach additional information to clarify your request for payment. |
| **75** | The service date shown for administration of the vaccine is prior to the purchase of the medicine. Please resubmit your claim and clarify the date(s) the medicine was purchased, and the date(s) the medicine(s) was administered. Please provide proof of purchase for the medicine and payment of administration costs along with any additional information to clarify your request for payment when resubmitting your claim. |
| **76** | Our records do not reflect a vaccine purchase for the administration fee you are submitting. Each administration fee claim must have a corresponding drug claim that is submitted prior to or on the same date of fill as the administration fee.Please resubmit your claim and clarify the date(s) the medicine was purchased and the date(s) the medicine(s) was administered. Please provide proof of purchase for the medicine and payment of administration costs along with any additional information to clarify your request for payment when resubmitting your claim. |
| **77** | Attached circled claim(s) have been rejected. Claim(s) have been processed by another insurance when Medicare Part D is Primary. |
| **78** | Your claim was submitted beyond the filing deadline. A claim must be submitted within three (3) years of the date of fill and the PBM received date to receive reimbursement. |
| **79** | The information you submitted does not clearly identify who would receive payment, should the claim be payable. Please clarify who should receive payment (**Example:** You or your physician) and resubmit your claim. Feel free to attach additional information to clarify your request for payment. |
| **80** | The physician DEA or NPI Number is missing or invalid. Please contact your physician for their DEA or NPI number so that we may process your claim. |
| **81** | The attached member has primary prescription drug coverage through Medicare Part D. Prescription drug claims covered by the VA are not eligible for reimbursement by a Medicare Part D plan. Please refer to the Medicare Part D Coordination of Benefits Guidance. |
| **83** | Please verify the completeness of all claims sent to our PBM for processing. Failure to include all necessary information may result in processing delays or rejects. The most common omissions are the cardholder’s complete identification number and the NCPDP number of the pharmacy and usual and customary charge. |
| **84** | We are unable to locate your pharmacy as active in our PBM member pharmacy. Please contact your pharmacy to ensure their information is correct in our system. |
| **85** | The plan sponsor does not accept Universal Claim Forms and requires that all claims be processed via the applicable system. |
| **86** | We have received a printout of claims for our cardholder from your pharmacy. Claims must be submitted to our PBM on Universal Claim Forms. |
| **87** | We do not handle coordination of benefits through the pharmacy. The cardholder must submit these claims on a Direct Reimbursement Claim form. |
| **88** | DUR Reject error. |
| **89** | The amount of your claim has been prorated because the quantity and /or days’ supply was greater than the limits selected by your plan sponsor. This means if the quantity filled is more than allowed for retail days’ supply, the claims will be prorated to reimburse for the days’ supply allowed rather than returning the claim unpaid. |
| **90** | Prior Authorization - The medicine you received requires prior approval by your plan sponsor. If you have any questions, please call the toll-free number on your Prescription card. |
| **91** | Plan Limitations Exceeded - Your plan provides coverage for a specific days’ supply or quantity for each fill or refill of a prescription. |
| **93** | Your plan sponsor requires a completed, signed and dated AT&T Prescription Reimbursement Claim Form with each claim submitted. Once you obtain the client-specific claim form, please complete it in full, sign and date it, and resubmit it for consideration under your benefit plan. |
| **104** | The signature of the subscriber is required to process your claim. |
| **606** | **Note:** Refer to the screenshot tab for a Care friendly description.  This occurs when the business decides to dispense a brand drug name when a generic is available AND the client wants the claim adjudicated with DAW9. RxClaim will reject the prescription, when mail receives this reject code, it will either create a new conflict or request that the user change the dispense drug to the brand drug OR the system will change the dispense drug to the brand. |
| **619** | Prescriber NPI required. |

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| **Related Documents** |

**Abbreviations/Definitions:** [Customer Care Abbreviations, Definitions, and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

[Paper Claims Letters Index (003500)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=854b5472-eb94-4adc-86eb-a8b09c623ac8)

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