Policy ID Mapping for CARC/RARC

Health Care Policy Code	Description	RARC Code	CARC Code	HIPAA Non-Par ADJ GRP	HIPAA ADJ GRP	Pend/Deny	Business Scenario
108	We are unable to establish the patient's eligibility. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	MA36 - Missing/incomplete/invalid patient name.	N/A	N/A	N/A	N/A	N/A
117	Benefits could not be determined because the submitted procedure number is not recognized or is no longer an accepted, standardized procedure code. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	M20 - Missing/incomplete/invalid HCPCS.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
119	Procedure code is not in the approved CDT code set. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee, upon receipt we will process the submitted	M51 - Missing/incomplete/invalid procedure code(s).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare	PI	PI	DENY	2

	service(s) in accordance with our processing guidelines.		Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
161	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with the appropriate procedure code, arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N37 - Missing/incomplete/invalid tooth number/letter.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
203	This is a orthodontic installment benefit payment.	N9 - Adjustment represents the estimated amount a previous payer may pay.	N/A	N/A	N/A	PAY	N/A
206	According to the enrollee's program, this procedure is a covered benefit only after a contractual waiting period has ended. You may use our online provider Tools for eligibility and benefits information, including remaining maximums and deductibles.	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
401	This procedure was has already been processed on a prior claim, or it is a	N111 - No appeal right except duplicate claim/service issue. This	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	duplicate of another procedure on this claim.	service was included in a claim that has been previously billed and adjudicated.					
402	This procedure was has already been processed on a prior claim, or it is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
403	This procedure was has already been processed on a prior claim, or it is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
404	This procedure was has already been processed on a prior claim, or it is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
408	This procedure was has already been processed on a prior claim, or it is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	18 - Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N/A	N/A	N/A	2
415	Our records show that this tooth was extracted	N640 - Exceeds number/frequency	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	previously. Therefore, we cannot make a benefit allowance for the requested procedure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	approved/allowed within time period.	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.				
448	According to our guidelines, the maximum allowance for mucogingival surgery is two sites per quadrant. This guideline is not met because there are more than two sites in the same quadrant. Please refer to Section Four of the Dentist Handbook for dental policy and guidelines for periodontal surgical procedures. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3

	(i.e., copies of x-rays, photos and/or clinical comments regarding the need to perform more than two sites in the same quadrant on the same date of service) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
455	Limitation applies as listed in Evidence of Coverage: For six months after delivery of a crown, the fee for any filling or repair is included at no cost, if done in the same dental facility.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PI	DENY	3
501	The allowance is based on the dental consultant's evaluation of the treatment performed.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	OA	DENY	3
503	This service is not a covered benefit of the enrollee's program. We have applied an alternate procedure number and allowance to ensure accurate processing. The patient is responsible for the amount indicated as "Patient Pays."	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

504	The submitted documentation does not support the payment of benefits for the procedure. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
505	The allowance reflects a fee deduction for a related procedure that was previously processed. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N357 - Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	B10 - Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	N/A	N/A	N/A	4
506	This procedure has been previously reviewed by our dental consultant, and the original benefit determination is unchanged.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
507	Non-definitive (incomplete) treatment is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N301 - Missing/incomplete/invalid procedure date(s).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PR	PI	DENY	2

			Service Payment Information REF), if present.				
508	Specialized techniques are not covered benefits of the enrollee's program. We have applied an alternate procedure number and allowance to ensure accurate processing. The patient is responsible for the amount indicated as "Patient Pays."	N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PR	PI	DENY	4
509	Specialized techniques are not covered benefits of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N156 - Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.	B8 - Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
510	Under our guidelines, restorative procedures for the repair of lesions due to any erosion, abrasion and abfraction are not a benefit. A tooth must exhibit significant structural loss from decay, failing large restorations, or fracture not attributable to the aforementioned causes. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	the service was performed to correct wear, abrasion rather than decay. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
511	Under our guidelines, procedures to correct congenital or developmental malformations are not covered. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the service was performed to correct congenital or developmental malformations. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
512	According to our guidelines, a consultation is not a benefit when other services are performed by the same provider during the same visit. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
515	This service is not a covered benefit of the enrollee's program because there is a less expensive, professionally acceptable alternative treatment available. We have applied an alternate procedure number and allowance to ensure accurate processing. The patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4
530	Based on the dental consultant's professional review of the submitted documentation, this service	N10 - Adjustment based on the findings of a review organization/professional consult/manual	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PR	PR	DENY	3

	is not a benefit of the enrollee's program because of questionable prognosis. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	adjudication/medical advisor/dental advisor/peer review.	Segment (loop 2110 Service Payment Information REF), if present.				
531	Under our guidelines, for a tooth to qualify for this service there must be a good long-term prognosis. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the service has an unfavorable prognosis. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
532	The periodontal health of a tooth to be crowned must be considered. Under our guidelines, teeth with uncontrolled or untreated	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PR	PI	DENY	3

	periodontal disease typically have a compromised long-term prognosis. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because the poor periodontal prognosis of the involved tooth or teeth. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	advisor/dental advisor/peer review.	Segment (loop 2110 Service Payment Information REF), if present.				
533	The endodontic prognosis of a tooth must be considered. Under our guidelines, a crown or retainer crown is not allowed on a tooth with untreated or unresolved periapical or periradicular pathology. Based on the dental consultant's professional review of the submitted documentation this guideline is not met	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	because the involved tooth has unresolved periapical pathology. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
564	Benefits could not be determined because of missing information. Please submit a new claim or pre-treatment estimate with clinical treatment narrative, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M29 - Missing operative note/report.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1
565	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided	PI	PI	DENY	2

	estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		(may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
566	Benefits could not be determined because of missing information. Please submit a new claim or pre-treatment estimate with the date for each service, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N301 - Missing/incomplete/invalid procedure date(s).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
567	Benefits could not be determined because of missing information. Please submit a new claim or pre-treatment estimate with patient's treatment plan, upon receipt we will process the submitted service(s) in	M135 - Missing/incomplete/invalid plan of treatment.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PR	PI	DENY	1

	accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
568	Benefits could not be determined because of missing information. Please submit a new claim or pre-treatment estimate with an oral pathology and/or operative report, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M30 - Missing pathology report.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1
569	Benefits could not be determined because of the nature of the radiographic images submitted. Please submit a new claim or pre-treatment estimate with dated, diagnostic radiographic images, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1

	processing, please do not attach a copy of this EOB to the new claim.						
570	Benefits could not be determined because of missing periapical radiographic images. Please submit a new claim or pre-treatment estimate with current and dated pre-operative periapical radiographic images of diagnostic quality, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1
572	Additional information is being requested. Please submit a new claim or pre-treatment estimate with dated and mounted post operative periapical radiographic images of diagnostic quality, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1

	processing, please do not attach a copy of this EOB to the new claim.						
573	Benefits could not be determined because of missing radiographic images. Please submit a new claim or pre-treatment estimate with a complete intraoral radiographic image series full mouth radiographic images of diagnostic quality, appropriately labeled and dated, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1
574	Benefits could not be determined because of missing periodontal information. Please submit a new claim or pre-treatment estimate with a current and dated periodontal charting, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in	N401 - Missing periodontal charting.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1

	processing, please do not attach a copy of this EOB to the new claim.						
575	Benefits could not be determined for this procedure because of missing periodontal information. Please submit a new claim or pre-treatment estimate, we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. The claim documentation should include any or all of the following clinical information as appropriate: millimeters of recession, frenum pull, mucoginigival defect, sulcus depth, restorative considerations and/or clinical photographs for each tooth.	N401 - Missing periodontal charting.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1
576	Benefits could not be determined without additional information. This benefit plan covers the submitted service(s) only if the patient has a history of prior periodontal therapy in	MA122 - Missing/incomplete/invalid initial treatment date.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	PR	PI	DENY	2

	two or more quadrants. Please submit a new claim or pre-treatment estimate with documentation of prior periodontal therapy and the nature of the therapy, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
577	Benefits could not be determined because of missing/conflicting orthodontic information. Please submit a new claim or pre-treatment estimate with the date appliances were placed, total case fee, initial banding fee, monthly treatment fees, and estimated number of months of treatment, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M135 - Missing/incomplete/invalid plan of treatment.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1

586	Benefits for this procedure could not be determined due to missing information. Please submit a new claim or pre-treatment estimate with current and dated post-operative periapical radiographic images clearly depicting the root apex, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1
601	This service is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
609	Our records show this provider is not enrolled and credentialed as a Delta Dental State Government Program provider. This service is only a covered benefit when the enrollee is treated by a provider	N95 - This provider type/provider specialty may not bill this service.	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.	PR	PR	N/A	3

	enrolled in the Delta Dental State Government Program.						
712	The enrollee's program excludes orthodontic benefits for the enrollee and spouse. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
718	According to our guidelines, the fee for this procedure is considered to be part of, and included in the fee for a completed service. Please refer to Section 4 of the Dentist Handbook for information regarding dental policy and clinical guidelines for this service.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
719	This procedure requires prior authorization, and the date of service must be within the authorization period.	M62 - Missing/incomplete/invalid treatment authorization code.	198 - Precertification/notification/authorization /pre-treatment exceeded.	PR	PI	N/A	3
746	No additional benefits are available because the maximum benefit for this service has already been provided. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

775	This service has exceeded the program's frequency limitation of once in a six-month period. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
776	This service has exceeded the program's frequency limitation within any twelve-month period. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M90 - Not covered more than once in a 12 month period.	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.	PR	PR	DENY	3
777	This service has exceeded the program's frequency limitation within a calendar year. Therefore, the patient is responsible for the amount indicated as "Patient Pays." You may use our online provider Tools for eligibility and benefits information, including remaining maximums and deductibles.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

778	This service has exceeded the program's frequency limitation within a twelve-month contract period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M90 - Not covered more than once in a 12 month period.	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.	PR	PR	DENY	3
779	The enrollee's program has a limitation of once in a three-year period for this service. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
780	The enrollee's program limits this service to once only. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	N117 - This service is paid only once in a patient's lifetime.	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.	PR	PR	DENY	3
786	The treatment of temporomandibular joint (TMJ) dysfunction and related services are not	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	covered benefits of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
788	Our records show that this tooth was extracted previously. Therefore, we cannot make a benefit allowance for the requested procedure. If you have additional information to provide, you may request a reevaluation.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	4
799	Benefits could not be determined because the submitted procedure number is not recognized. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N301 - Missing/incomplete/invalid procedure date(s).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
989	Based on additional information received, we	N10 - Adjustment based on the findings of a review organization/professional	N/A	N/A	N/A	PAY	N/A

	have recalculated a previous claim.	consult/manual adjudication/medical advisor/dental advisor/peer review.					
990	The original calculation of benefits contained an error. Therefore, we have recalculated the previous claim and adjusted the payment.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	N/A	N/A	N/A	PAY	N/A
992	Based on the consultant review of the submitted documentation, an additional allowance for this procedure has been made.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PI	DENY	3
995	Benefits could not be determined because of missing or insufficient primary coverage information. Please submit a new claim or pre-treatment estimate with a copy of the denial and/or payment notification from the primary carrier, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N/A	N/A	N/A	N/A

10L	Limitation applies as listed in Evidence of Coverage: Unless done by the assigned dentist solely to aid in diagnosis, study models/casts are not covered as a separate procedure.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
10M	Limitation applies as listed in Evidence of Coverage: There is a history for the enrollee of another denture tissue conditioning (placing temporary soft lining in the denture). Based upon how frequently this service is covered on the enrollee's plan, this tissue conditioning is not a benefit.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PR	DENY	3
10N	Limitation applies as listed in Evidence of Coverage: Replacing a filling, inlay, onlay, crown, bridge or denture is not covered, if it is serviceable or can be made so.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
11V	Blank Eye Procedure with copay	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Identification Segment (loop 2110 Service Payment Information REF), if present.				
12V	Other Procedure Found With 00125	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
14V	Duplicate Proc with Same Eye	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
19V	Invalid Eye	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1E3	Exclusion applies as listed in Evidence of Coverage: There is no coverage for any dental procedure started before the enrollee's eligibility with the plan.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

1E4	Exclusion applies as listed in Evidence of Coverage: There is no coverage for any dental procedure started after termination of eligibility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
1E5	No coverage for hospitalization, outpatient surgery centers, extended care facilities	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
1E6	Limitation applies as listed in Evidence of Coverage: If the accidental trauma occurred before enrollee became eligible on DeltaCare, the Accidental Injury Rider does not cover related dental treatment.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
1HF	Benefits could not be determined because the submitted fee is invalid. Please submit a new claim or pre-treatment estimate with correct and complete itemized fee information, upon receipt we will process the submitted service(s) in	M49 - Missing/incomplete/invalid value code(s) or amount(s).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PI	PI	DENY	2

	accordance with our processing guidelines.		Service Payment Information REF), if present.				
1IC	Benefits could not be determined because of missing/conflicting information. Some fields on the submitted claim form were not completed or populated with incorrect information. Upon receipt of a new claim with complete/corrected information, we will process the submitted service(s) in accordance with our processing guidelines.	M49 - Missing/incomplete/invalid value code(s) or amount(s).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
1ID	This service requires the submission of supporting documentation such as radiographs, periodontal chart, narrative report. Please refer to the Dentist Handbook for a complete list of documentation requirements for this service.	N683 - Missing/Incomplete/Invalid prior treatment documentation.	250 - The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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).	PI	PI	DENY	1
1IG	Ineligible - Excluded Group	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

1L0	Limitation applies as listed in Evidence of Coverage: For six months after delivery of a new denture, the fee for adjustment and tissue conditioning of that denture are included at no cost, if done in the same dental facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
1P1	We have applied an alternate procedure number and allowance to ensure accurate processing.	N70 - Consolidated billing and payment applies.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	4
1P4	This procedure requires prior authorization, and the date of service must be within the authorization period.	N54 - Claim information is inconsistent with pre-certified/authorized services.	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.	PR	PI	DENY	3
1PP	Your orthodontic treatment request has been received and is in our system. There is no payment with this notice. Periodic payments will be automatically issued starting in the next payment cycle, subject to the patient's continued	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	eligibility and contract maximum.						
1SF	We are unable to process the claim because the fee(s) are either missing, invalid or are not itemized appropriately. Please submit a new claim or pre-treatment estimate with correct fee information, showing each procedure number and its associated fee, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	M79 - Missing/incomplete/invalid charge.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
1UC	Closed Office	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1UD	Pending - Duplicate Found on Form	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3

1UP	This exceeds your plan benefit. Therefore, we denied this service.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
1V1	The combined fees for radiographic images are equal to or more than the fee for a complete radiographic image series. Therefore, according to our guidelines, the radiographic images are considered to be equivalent to a complete series. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N22 - Alert: This procedure code was added/changed because it more accurately describes the services rendered.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	4
1V2	Voided Form - Per Provider	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1V4	Voided Form - Termed Member	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	27 - Expenses incurred after coverage terminated.	PI	PI	DENY	3
1V5	Voided Form - Ineligible Member	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
1V6	Voided Form - Over 6 Months	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1V7	Voided Form - Incomplete Info.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1V8	Voided Form - Over 1 Year	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PI	PI	DENY	3
1V9	Voided Form - Duplicate	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
1VA	Voided Procedure - Per Provider	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
1VB	Voided Procedure - Follow Up Visit	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1VC	Voided Procedure - Duplicate	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
1VD	Voided Procedure	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
1VE	Voided - Proc Rpted on Same Visit	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Identification Segment (loop 2110 Service Payment Information REF), if present.				
1VI	Voided Procedure - Invalid Code	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
1VM	Voided Procedure - Missing Tth/Quad	N37 - Missing/incomplete/invalid tooth number/letter.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
1VT	Voided Procedure - Invalid Tth/Quad	N37 - Missing/incomplete/invalid tooth number/letter.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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	PI	PI	DENY	2

			ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
1VW	Benefits could not be determined because the submitted fees on the vision claim form and the fees on the attached receipt and/or super bill do not match, or because of missing/combined treatment information. Upon receipt of a new vision claim with corrected submitted fee and /or specific treatment information, the submitted service(s) will be processed in accordance with our processing guidelines.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
202	The payment was calculated based on the coordination of benefits.	N9 - Adjustment represents the estimated amount a previous payer may pay.	N/A	N/A	N/A	PAY	N/A
2CC	According to the enrollee's plan, this procedure is a covered benefit only after a waiting period has ended. Therefore, the patient is responsible for the amount indicated as "Patient Pays." If the enrollee can provide proof of dental coverage	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3

	that occurred immediately prior to the election of this plan, all or part of this plan's waiting period may be satisfied. Please provide a copy of the enrollee's Evidence of Coverage (EOC) and last bill from the prior carrier, and the amount of time the enrollee was covered under the prior coverage will be credited to the waiting period under the enrollee's current plan. Please see instructions below on how the enrollee may request a review of this case after the prior coverage information has been submitted.						
2CD	The requested services cannot be processed because we are not the processing administrator. Please contact the enrollee for claim submission information.	N418 - Misrouted claim. See the payer's claim submission instructions.	109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	PI	PI	DENY	3
2DL	The deadline for submitting this procedure/claim has expired.	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PR	PI	DENY	3
2DX	The deadline for submitting this procedure/claim has expired.	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PR	PR	DENY	3

2GD	The Delta Dental processing company for this group has changed. Please go to www.deltadental.com and look up this member's eligibility under "Find your Delta Dental" to find the correct Delta Dental Plan for claims submission.	N418 - Misrouted claim. See the payer's claim submission instructions.	109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	PI	PI	DENY	3
2GL	The deadline for submitting this procedure/claim has expired.	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PR	PI	DENY	3
2MD	The requested services cannot be processed under the patient's plan because the policy requirements have not been met. Therefore, the patient is responsible for the amount indicated as "Patient Pays".	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PR	PR	DENY	3
2PR	The requested services cannot be processed under the patient's group plan. Therefore, the patient is responsible for the amount indicated as "Patient Pays".	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PR	PR	DENY	3
2RO	The patient is not eligible under this program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PR	PR	DENY	3
2VD	Vision is not a benefit. This patient may be eligible for vision benefits under a	N418 - Misrouted claim. See the payer's claim submission instructions.	109 - Claim/service not covered by this payer/contractor. You must send the	PI	PI	DENY	3

	separate GVS plan. Please submit any vision claim to First American Administrators, Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111.		claim/service to the correct payer/contractor.				
307	We are unable to process this claim because the treating provider is not in our system. Please verify that the provider data is valid with the local Delta Dental member company prior to any additional claim submissions.	M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	242 - Services not provided by network/primary care providers.	PI	PI	DENY	3
308	The fees for endodontic surgical procedures that are performed on the same tooth within 24-months of the original procedure are included in the fee for the original service. A separate fee is not billable to the patient.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
3D1	Benefits could not be determined because the Billing Provider's Tax Identification Number (TIN)/Treating Provider's License Number, National Provider Identifier (NPI), and/or the practice location submitted is missing or is different from the one that	MA115 - Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PR	PI	DENY	2

	we have on file for this provider and office location. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure the billing provider's TIN and/or practice location is registered before submitting additional claims. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.		Service Payment Information REF), if present.				
3D2	This National Provider Identifier (NPI) does not match the information we have on file for this provider and office. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure the provider's NPI is registered with Dentegra.	N280 - Missing/incomplete/invalid pay-to provider primary identifier.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
3D3	The billing provider's Tax Identification Number (TIN) is missing or is different	MA113 - Incomplete/invalid taxpayer identification	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims	PR	PI	DENY	2

	from the one that we have on file for this provider and office location. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure the billing provider's TIN is registered with Dentegra before submitting additional claims.	number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.	attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
3D4	The practice location submitted on the claim is missing or is different from the one that we have on file. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure this practice location is registered with Dentegra before submitting additional claims.	MA115 - Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
3ED	Benefits could not be determined because provider information and proof of payment were missing. Please submit a new claim or pre-treatment estimate/request providing the complete provider	N354 - Incomplete/invalid invoice.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or	PR	PR	DENY	1

	name, office/clinic address, with itemized proof of payment to the same provider, upon receipt we will process the submitted service(s) in accordance with your plan.		Remittance Advice Remark Code that is not an ALERT).				
3FA	The provider or billing entity is under sanction by the US Department of the Treasury Office of Foreign Assets Control (OFAC). U.S. companies are prohibited from conducting business with a sanctioned entity, therefore we cannot authorize or pay for this service.	N808 - Not covered for this provider type / provider specialty.	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.	PR	PI	DENY	3
3HP	All providers participating in the Washington D.C. Medicaid Program must register with the District of Columbia Medicaid Program. The NPI number submitted does not match the NPI registered with the District of Columbia Medicaid Program. Please ensure the NPI is correctly registered with Delta Dental and the District of Columbia before submitting additional claims. The DC Provider Data Management System	MA115 - Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	website can be found at: https://www.dcpdms.com/.						
3IG	We cannot authorize or pay for this service because you are on the U.S. Department of Health and Human Services Office of Inspector General exclusions list. We are required to deny payment for any health care service you provide during the time period that you are included on the exclusion list.	N808 - Not covered for this provider type / provider specialty.	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.	PR	PI	DENY	3
3MR	Benefits could not be determined because the member signature is missing. Please submit a new claim or pre-treatment estimate with the member signature, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	MA71 - Missing/incomplete/invalid provider representative signature date.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
3NP	Benefits could not be determined because proof of payment was missing. Please submit a new claim or pre-treatment estimate/request providing itemized proof of payment to the provider who	N354 - Incomplete/invalid invoice.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or	PR	PR	DENY	1

	performed the services, upon receipt we will process the submitted service(s) in accordance with your plan.		Remittance Advice Remark Code that is not an ALERT).				
3OD	Benefits could not be determined because of missing, insufficient, or illegible information. Please submit a new claim or pre-treatment estimate/request providing a complete and itemized list of services provided including the fee, the complete provider name, office/clinic address, with itemized proof of payment to the same provider, upon receipt we will process the submitted service(s) in accordance with your plan.	N354 - Incomplete/invalid invoice.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
3OE	Benefits could not be determined because the proof of payment does not match the dates and/or charges for services provided. Please submit a new claim or pre-treatment estimate/request providing a correct itemized proof of payment to the provider who performed the service(s), upon receipt we will process the submitted	N354 - Incomplete/invalid invoice.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	service(s) in accordance with your plan.						
3OF	Benefits could not be determined because proof of payment/receipt is missing information, insufficient, or illegible. Please submit a new claim or pre-treatment estimate/request providing itemized proof of payment to the provider who performed the services, upon receipt we will process the submitted service(s) in accordance with your plan.	N354 - Incomplete/invalid invoice.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
3PP	Benefits could not be determined because provider information was missing. Please submit a new claim or pre-treatment estimate/request providing the complete provider name, office/clinic address upon receipt we will process the submitted service(s) in accordance with your plan.	N354 - Incomplete/invalid invoice.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PR	DENY	1
3PS	Benefits could not be determined because the provider signature is missing. Please submit a new claim or pre-treatment estimate with the provider signature, upon receipt we	MA71 - Missing/incomplete/invalid provider representative signature date.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	PI	PI	DENY	2

	will process the submitted service(s) in accordance with our processing guidelines.		Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
3SA	We cannot authorize or pay for this service. The provider or billing office is excluded from participating in Medicare and Medicaid because they are under exclusion by the Federal Government System for Award Management (SAM) procurement system.	N808 - Not covered for this provider type / provider specialty.	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.	PR	PI	DENY	3
3SE	The provider is excluded from participation in the Medicaid program. We cannot authorize or issue payment for any service.	N808 - Not covered for this provider type / provider specialty.	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.	PR	PI	DENY	3
3SR	Benefits could not be determined because the provider signature is missing. Please submit a new claim or pre-treatment estimate with the provider signature, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	M71 - Total payment reduced due to overlap of tests billed.	111 - Not covered unless the provider accepts assignment.	N/A	N/A	PEND	N/A

3X1	Our records show this provider is not enrolled and credentialed as a Delta Dental State Government Program provider. This service is only a covered benefit when the enrollee is treated by a provider enrolled in the Delta Dental State Government Program.	M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	242 - Services not provided by network/primary care providers.	PR	PI	DENY	3
3X3	Benefits could not be determined because the Billing Provider's Tax Identification Number (TIN)/Treating Provider's License Number, and/or the practice location submitted is missing or is different from the one that we have on file for this provider and office location. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure the billing provider's TIN and/or practice location is registered with the local Delta Dental member company before submitting additional claims. Please submit a new claim or pre-treatment estimate with correct and complete	MA113 - Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. Claims or pre-treatment estimates may be submitted online, for information go to Provider Tools at deltadentalins.com/dentists.						
3X4	The practice location submitted on the claim is missing or is different from the one that we have on file. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure this practice location is registered with the local Delta Dental member company before submitting additional claims.	MA115 - Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
3X7	The National Provider Identifier (NPI) information was omitted on the claim. Please include this information on the claim and submit a new claim for processing.	N280 - Missing/incomplete/invalid pay-to provider primary identifier.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PR	PI	DENY	2

			Service Payment Information REF), if present.				
3X8	The rendering provider information was omitted on the claim. Please include rendering provider information on the service line(s) and submit a new claim for processing.	N32 - Claim must be submitted by the provider who rendered the service.	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.	PR	PI	DENY	3
3X9	The rendering provider information was omitted on the claim. Please include rendering provider information on the service line(s) and submit a new claim for processing.	N32 - Claim must be submitted by the provider who rendered the service.	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.	PR	PI	DENY	3
3XB	This National Provider Identifier (NPI) does not match the information we have on file for this provider and office. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure the provider's NPI is registered with the local Delta Dental.	N280 - Missing/incomplete/invalid pay-to provider primary identifier.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
3ZI	This claim was processed as out of area services.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

			Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
410	Under our guidelines, prophylaxis procedures and gross debridement are not allowable on the same date of service as procedure D4346: scaling in presence of generalized moderate or severe gingival inflammation.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
411	Under our guidelines, benefits for sealants/preventive resin restorations are limited to permanent teeth without decay or restorations on the same surface as the sealant. Our claim history shows a history of a restoration is already on the same surface as the sealant. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330;	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

	Sacramento, CA 95899-7330.						
412	Our records indicate that a space maintainer and its replacement were previously provided. Additional replacements are not covered under the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
413	Limitation applies as listed in Evidence of Coverage: A sealant is only covered if placed on a permanent first or second molar that has no decay or existing restoration.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
414	A duplicate claim was received. There is a history of the same procedure being provided for this enrollee on the same date of service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
423	The enrollee's program excludes services performed for cosmetic purposes. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N383 - Not covered when deemed cosmetic.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

424	Exclusion applies as listed in Evidence of Coverage: There is no coverage for treatment done solely for cosmetics.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
425	Under our guidelines, the fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is included in the fee for the original procedure performed on the same tooth within 24-months of the original procedure if submitted by the same dentist/dental office. Our claims history shows this service was provided less than 24-months prior to the submitted service. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3

	Box 997330; Sacramento, CA 95899-7330.						
426	Benefits could not be determined because of missing periodontal information. No more than two quadrants of scaling and root planing are benefited on the same date of service in the absence of supporting documentation, which must include the reason for performing more than two quadrants on the same date of service. Please submit a new claim with radiographic images, a current and dated periodontal chart, and a copy of the patient treatment record. Upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N402 - Incomplete/invalid periodontal charting.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	N/A	1
440	According to our guidelines, the fee for this procedure is considered part of and included in the fee for periodontal services. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

441	According to our guidelines, the fee for osseous surgery includes the fees for three months of postoperative care and any surgical re-entry, and scaling and root planing for three years. Exceptions involving special circumstances require a written report. These guidelines are not met because, this service was performed within that time limit. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
442	Under our guidelines, scaling and root planing performed in the same quadrant as osseous surgery must precede the surgery by at least four weeks. A waiting period of a minimum of four weeks should follow periodontal	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	scaling and root planing to allow for healing and re-evaluation and to assess tissue response. This guideline is not met because the service was performed prior to the minimum waiting period. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
443	According to our guidelines, when periodontal root planing is performed in the same quadrant within four weeks of (prior to) periodontal surgery, the fee for the root planing is considered part of and included in the fee for that surgery. Periodontal surgery was performed in the same quadrant within six-months of the root planing procedure. If you wish to	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
444	According to our guidelines, the fee for osseous surgery includes the fees for three months of postoperative care and any surgical re-entry, and scaling and root planing for three years. Exceptions involving special circumstances require a written report. These guidelines are not met because, this service was performed within that time limit. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
445	According to our guidelines, bone grafts, soft tissue grafts and guided tissue regeneration are not covered benefits when performed in conjunction with ridge augmentation, apicoectomies, extractions, implants, or other non-periodontal surgical procedures. These guidelines are not met because this service was performed with one of the above-mentioned procedures or in an extraction site. Please refer to Section Four of the Dentist Handbook for dental policy and guidelines for periodontal surgical procedures. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
446	Exclusion applies as listed in Evidence of Coverage: The submitted procedure code may not be used when bone grafting is done after the loss of one or more teeth to increase or preserve the arch, which is not a covered service in the enrollee's contract under Schedule A.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
447	In the absence of supporting documentation, no more than two quadrants of scaling and root planing are allowable on the same date of service. Supporting documentation includes evidence of length of the appointment in which the procedures were provided, information related to local anesthetic used, and/or reason for performing more than two quadrants on the same date of service. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting	N20 - Service not payable with other service rendered on the same date.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	documentation (i.e., copies of x-rays, photos and/or clinical comments regarding the need to perform more than two quadrants on the same date of service) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
449	The fee for gingival irrigation is included in the fee for any periodontal services performed on the same date of service. Please refer to Section Four of the Dentist Handbook for dental policy and guidelines for gingival irrigation. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N20 - Service not payable with other service rendered on the same date.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
461	Under our guidelines, guided tissue regeneration is not a benefit in conjunction with soft tissue grafts in the same surgical area. Soft tissue grafts were performed in the same area; therefore, the guided tissue regeneration is not covered. If you wish to request a reevaluation of this action,	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4

	use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
4CA	Under our guidelines, this service is reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances, or congenital defects. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the service was not performed for the above reasons. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3

	Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
4M7	Dental coding updated: This is not a separately payable service. Under our guidelines the fee for this procedure is included in the fee for another dental procedure. For this reason we are unable to pay this charge. Neither the plan nor enrollee is responsible for payment of this service.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	4
4M8	Dental coding updated: Need for incision and drainage is not apparent. A related procedure completed on this date would generally establish adequate drainage without the need for separate surgical incision. Neither the plan nor enrollee is responsible for any such unbundled component.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
4NC	Individual no longer covered. Please submit the claim to the member's current carrier.	N747 - This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.	109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	PI	PI	DENY	3
4SH	According to our guidelines, allowance has been previously provided for a sealant or preventive resin	M86 - Service denied because payment already made for same/similar	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	PR	PI	DENY	3

	restoration procedure. The patient is responsible for the amount indicated as "Patient Pays."	procedure within set time frame.	Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
4U1	This procedure was previously processed or is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
513	Limitation applies as listed in the Evidence of Coverage: Re-treatment of root canal therapy is only covered if there is evidence of an abscess and/or current pathology.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
514	Exclusion applies as listed in Evidence of Coverage: The long-term prognosis and the status of an endodontically treated tooth must be considered. Under our guidelines, the placement, density and/or depth of the existing root canal filling material should provide an adequate seal. Based on the dental consultant's professional review of the submitted documentation these guidelines are not met	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	because the placement, density and/or depth of the existing root canal filling material has not prevented an infection or other problems from occurring. A history of failed endodontic treatment indicates a poor prognosis for the same or similar treatment. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
516	The procedure has been previously reviewed by our dental consultant, and the original benefit determination is unchanged.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
517	The procedure has been previously reviewed by our dental consultant, and the original benefit determination is unchanged.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PR	PR	DENY	3

		advisor/dental advisor/peer review.	Segment (loop 2110 Service Payment Information REF), if present.				
518	Limitation applies as listed in Evidence of Coverage: Under our guidelines, to qualify a fixed bridge abutment coverage a tooth must demonstrate significant loss of tooth structure (greater than 50%) including loss, or undermining, of a cusp or incisal angle. These guidelines are not met because, based on the consultant's professional review of the submitted information, the tooth does not demonstrate significant loss of tooth structure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
519	Limitation applies as listed in Evidence of Coverage: For	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	adults, a stayplate (interim partial denture) is only covered to replace an anterior tooth or teeth during the healing period.	information about restrictions for this service.	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.				
51D	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The prognosis is under review. The treating provider must submit a narrative describing the size and location of any root perforation(s). Please submit a new claim or pre-treatment estimate or new pre determination with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
51L	Consultation approved, however, the treating provider must submit a narrative describing the size and location of any root perforation(s) if authorization is submitted for other services.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

51U	Exclusion applies: Medicaid does not cover alveoloplasty	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
520	Limitation applies as listed in Evidence of Coverage: Posterior bridges are not covered if a pontic (artificial tooth) will be supported on only one side (cantilevered).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
521	Limitation applies as listed in Evidence of Coverage: A new removable partial denture is not covered, if there are inadequate remaining teeth in an arch to support that partial denture.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
522	Limitation applies as listed in Evidence of Coverage: An inlay, onlay, crown, fixed bridge is covered only if the tooth cannot be restored with a filling.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
523	Limitation applies as listed in Evidence of Coverage: A	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	new filling is not covered unless the tooth is decayed, fractured or has a filling that has been lost or is defective.	information about restrictions for this service.	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.				
524	Exclusion applies as listed in Evidence of Coverage: There is no coverage for full mouth reconstruction (a total of 10 or more new inlays, onlays, crowns or units of fixed bridgework). Other covered procedures are not excluded.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
525	Limitation applies as listed in Evidence of Coverage: Under our guidelines, to qualify for a fixed bridge abutment a tooth must demonstrate significant loss of tooth structure (greater than 50%) including loss, or undermining, of a cusp or incisal angle. If the teeth retaining a posterior fixed bridge would be crowned solely to fabricate a fixed partial denture bridge, and does not otherwise require a new crown, then the covered procedure is a removable partial denture. These guidelines are not	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	met because, based on the consultant's professional review of the submitted information, the tooth does not demonstrate significant loss of tooth structure. A fixed partial denture would be an optional service. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
526	Enrollee's copayment exceeds lab charge, no reimbursement available.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
527	Exclusion applies as listed in Evidence of Coverage: There is no coverage for a procedure for the enrollee, if the service has a poor	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	chance of success and/or will fail prematurely.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
528	Dental coding updated: The definition of the code for debridement (D4355) specifies the removal of subgingival and/or supragingival calculus to permit periodontal probing and assessment. Due to an absence of any significant calculus deposits, the submitted code has been updated to one for prophylaxis.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
529	Exclusion applies as listed in Evidence of Coverage: There is no coverage for a dental procedure, if the prognosis for that procedure's success is poor or the tooth has a poor prognosis itself. Previous periodontal surgery has failed. Additional surgery would result in the further loss of periodontal support.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
52D	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The prognosis is under review. The treating provider must submit a	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	narrative describing the size and location of any tooth or root fracture. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
52L	This procedure was re-evaluated by a second dental consultant and the original benefit determination remains unchanged.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
52U	Exclusion applies: Medicaid does not cover treatment of temporomandibular joint syndrome or its prevention, sequela, subluxation, therapy, arthrostomy, meniscectomy or condylectomy.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
52V	Duplicate Exam Found	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PI	PI	DENY	3

		information about restrictions for this service.	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.				
534	The long-term prognosis of a tooth must be considered. Under our guidelines, when determining a benefit allowance for endodontic treatment the tooth must have an adequate crown to root ratio. This guideline is not met because, based on the consultant's professional review of the submitted information, the root system is not sufficient to support the tooth under normal stresses. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
535	Limitation applies as listed in Evidence of Coverage:	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	Excision of a frenum is a benefit only when the frenum causes limited mobility of the tongue, a large space between secondary (permanent) teeth, or interferes with a prosthetic appliance.	information about restrictions for this service.	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.				
536	Exclusion applies as listed in Evidence of Coverage: There is no coverage to correct an over-erupted (super-erupted) tooth or alter vertical dimension (change how far down an enrollee bites to close his/her mouth) with fixed bridges.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
537	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. It appears that the removal of this tooth would be within the scope of the assigned facility. The provider must submit a narrative and documentation evidencing why the service requires a specialist. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
538	Exclusion applies as listed in Evidence of Coverage: For a dental service to be covered, it must be consistent with the enrollee's dental condition and generally accepted professional standards. The submitted dental records, and the enrollee's apparent dental status, do not support this service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
539	Exclusion applies as listed in Evidence of Coverage: Under our guidelines, procedures to correct congenital or developmental malformations are not covered. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the service was performed to correct congenital or	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	developmental malformations. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
53A	The long-term prognosis of a tooth must be considered. Under our guidelines, when determining a benefit allowance for endodontic treatment the tooth must have a sound root structure free of internal or external resorption or perforations. This guideline is not met because based on the consultant's professional review of the submitted information the root demonstrates internal resorption or furcal perforation. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
53B	The long-term prognosis of a tooth must be considered. Under our guidelines, the following factor is considered when determining a benefit allowance for endodontic treatment: Teeth must not have uncontrolled or untreated periodontal disease. This guideline is not met because, based on the consultant's professional review of the submitted information, there is excessive loss of bone support which has weakened support to the tooth/teeth so that the success of the service is questionable. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
53D	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The periradicular surgery is under review. It appears that conventional endodontic re-treatment may be the more appropriate alternative. The provider must submit a narrative describing current pathology and why periradicular surgery is indicated instead of re-treatment. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	attach a copy of this EOB to the new claim.						
53U	Benefit is limited: An alveolus closed reduction (D7670) is open to services provided by primary children's hospital cleft palate clinic dentist.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
53V	Duplicate Frame/Lens	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
540	Payment is based on the maximum allowance for this service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
543	No additional benefits are available because the maximum benefit for this service has already been provided. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
54D	Benefits decision delayed: The plan cannot make a	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	benefit decision without all reasonably necessary information. The submitted radiograph shows root canal therapy of another tooth. The provider must confirm the tooth number and submit periapical x-rays showing the tooth. Claims for completed endodontic services must be submitted with periapicals made before and after treatment. Submitted radiographs must be dated and marked "Pre-op or Post-op". Please submit a new claim or pre-treatment estimate or new pre determination with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	information about restrictions for this service.	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.				
54U	Benefit for general anesthesia is limited: For patient 4 years of age or younger, prior approval is not required.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

551	Exclusion applies as listed in Evidence of Coverage: Under our guidelines, there is no coverage to restore or stabilize tooth structure worn away by abrasion, attrition, or erosion. This guideline is not met because based on the consultant's professional review of the submitted information the tooth structure is lost due to wear. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
552	Exclusion applies as listed in Evidence of Coverage: Whether erupted or not, there is no coverage to remove a tooth solely to eliminate the possibility of future problems.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
553	Exclusion applies as listed in the Evidence of Coverage:	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	For a dental service to be covered, it must be consistent with the enrollee's dental condition and generally accepted professional standards. The Plan does not have history of active periodontal treatment.	information about restrictions for this service.	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.				
554	Exclusion applies as listed in Evidence of Coverage: Whether erupted or not, there is no coverage to remove a tooth solely for orthodontic reasons.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
555	Exclusion applies as listed in Evidence of Coverage: There is no coverage for a dental procedure, if the prognosis for that procedure's success is poor or the tooth itself has a poor prognosis.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
556	This is not an emergency service. We did not receive a request for prior authorization as outlined in the Provider Handbook. Therefore, we are unable to pay for this service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

557	Under our guidelines, to qualify for crown or fixed bridge retainer a tooth must demonstrate significant loss of tooth structure (greater than 50%) including loss, or undermining, of a cusp or incisal angle. These guidelines are not met because, based on the consultant's professional review of the submitted information, the tooth does not demonstrate significant loss of tooth structure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
558	An onlay is appropriate when the restoration restores or replaces one or more cusps as well as a portion of the occlusal surface, and must extend to the proximal and facial or	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	lingual surfaces of the restored cusp or cusps.						
559	The long-term prognosis of a tooth must be considered. Under our guidelines, when determining a benefit allowance for endodontic treatment there must be a reasonable long-term prognosis for the tooth; teeth must not have uncontrolled or untreated periodontal disease. This guideline is not met because based on the consultant's professional review of the submitted information the tooth has untreated periodontal disease. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
55D	Benefits decision delayed: The plan cannot make a benefit decision without all	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PR	PR	DENY	3

	reasonably necessary information. Bitewing and other radiographs, which do not show the apex of the root, are inadequate for this endodontic procedure. The provider must submit periapical x-rays showing the tooth. Claims for completed endodontic services must be submitted with periapicals made before and after treatment. Submitted radiographs must be dated and marked "Pre-op or Post-op". Please submit a new claim or pre-treatment estimate or new pre determination with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	information about restrictions for this service.	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.				
55N	This is not an emergency service. We did not receive a request for prior approval as outlined in the Provider Handbook. Therefore, we are unable to pay for this service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

55U	Benefit for general anesthesia is limited: For a member over 4 years of age, they must submit copy of the patient's records documenting a physical or mental disability or other condition which necessitates the use of general anesthesia. Anxiety does not qualify as a medical condition.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
560	The long-term prognosis of a restoration must be considered. Under our guidelines, the functional occlusion of the entire dentition must be considered prior to implant placement. The length, width and location of implants must be appropriate for the clinical condition and allow for adequate function of the implant supported restoration/prosthesis. These guidelines are not met because based on the consultant's professional review of the submitted information the length, width and location of implants are not adequate	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	to support a restoration/prosthesis. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
56D	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph(s) is not of diagnostic quality. The provider must submit additional radiograph(s) that adequately depict the tooth and are free of stains, streaks, fogging, distortion or other defects, which would compromise diagnostic quality. For endodontic procedures, bitewing and other radiographs, which do not show the apex of the root, are inadequate. Claims for	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	completed endodontic services must be submitted with periapicals made before and after treatment. Submitted radiographs must be dated and marked "Pre-op or Post-op". Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
56U	Benefit for general anesthesia is limited: For a patient 5 - 8 years of age and without physical or mental disability, the patient must have a documented condition such as a failure and inability to treat when using a premedication which justifies the use of general anesthesia.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
571	Exclusion applies as listed in Evidence of Coverage: Without the plan's express	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PR	PR	DENY	3

	prior approval, there is no coverage for routine services performed outside the assigned facility. This treatment is the responsibility of your assigned general dentist who has received capitation payment from the plan. When performed by the assigned general dentist, the enrollee is responsible only for applicable copayments.	information about restrictions for this service.	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.				
578	The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph (documentation) does not verify that this procedure has been completed. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

579	The plan cannot make a benefit decision without all reasonably necessary information. This tooth appears to be missing on the submitted radiograph(s). Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
57D	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a narrative indicating when conventional endodontic re-treatment was performed. If retreatment was not yet attempted or performed, document why not. Please submit a new claim or pre-treatment estimate with correct and complete	N705 - Incomplete/invalid documentation.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
57U	Benefit for general anesthesia is limited: For a patient at least 9 years of age and without physical or mental disability, the patient must have a documented condition such as a failure and inability to treat when using a pre-medication which justifies the use of general anesthesia, or must be in conjunction with the covered extraction of a partial or full boney impacted third molar.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
582	Benefits could not be determined because of missing information. This procedure may be covered under the enrollee's medical carrier. Upon receipt of a new claim with either a copy of a finalized denial or payment from the medical	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1

	carrier, we will process the submitted service(s) in accordance with our processing guidelines.						
584	Exclusion applies as listed in Evidence of Coverage: The plan has no record of the assigned facility requesting authorization for specialty care services.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
585	Exclusion applies as listed in Evidence of Coverage: For determining benefits, a primary tooth that is retained is not considered a permanent tooth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
587	The Plan cannot make a benefit decision without all reasonably necessary information. There is insufficient documentation to process the claim. Resubmit with a supporting narrative regarding the nature of the visit. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
588	Limitation applies as listed in Evidence of Coverage: There is a history of a previous cleaning (prophylaxis or periodontal maintenance visit) for the enrollee. Based upon how frequently this service is covered on the enrollee's plan, this cleaning is not a benefit.	M90 - Not covered more than once in a 12 month period.	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.	PR	PR	DENY	3
589	The plan cannot make a benefit decision without all reasonably necessary information. The provider must resubmit with a copy of chart documentation that evidences chronic pain associated with this specific tooth for reconsideration. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

	processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
58U	Benefit is limited: General anesthesia may be performed by a dentist or oral surgeon possessing the proper Class IV permit under State Licensure. The provider may choose to perform his or her own anesthesia with the support staff required by State Licensing or may elect to have another properly licensed individual perform the anesthesia.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
590	Benefits could not be determined because of missing information about the previous coverage and benefits paid. Please submit a new claim or pre-treatment estimate with a copy of the payment information from the previous carrier, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N479 - Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	N/A	1

591	Benefits could not be determined because of missing orthodontic information from the primary plan. Please submit a new claim or pre-treatment estimate with an itemized copy of the denial and/or payment notification, including the patient's orthodontic lifetime maximum and benefit level (i.e. the percentage paid by the enrollee's plan), upon receipt we will process the submitted service(s) is accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N463 - Missing support data for claim.	250 - The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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).	PR	PI	N/A	1
592	Limitation applies as listed in Evidence of Coverage: If the enrollee is under 16 years old, and a permanent tooth is lost, only a removable resin denture or stayplate is covered to replace it.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
597	We are unable to process this claim for treatment extension. Upon receipt of	N463 - Missing support data for claim.	250 - The attachment/other documentation that was received was the incorrect attachment/document. The	PR	PI	DENY	1

	new claim with a new total case fee and reason for the extension upon receipt we will process the submitted service(s) in accordance with our processing guidelines.		expected attachment/document is still missing. 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).				
59D	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a narrative indicating if the tooth's root canal system was previous accessed and/or filled. If this is endodontic retreatment, when was the previously root canal therapy completed and was it done at the same dental office? Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

59U	Benefit is limited: General anesthesia performed at a hospital or ambulatory surgical center is covered by Medicaid Fee-for-Service and should be submitted to the Utah Department of Health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5A0	The long-term prognosis of an implant must be considered. Under our guidelines, when determining a benefit allowance for an implant-supported crown, bridge, partial or full denture, the implant must demonstrate osseointegration. This guideline is not met because, based on the consultant's professional review of the submitted information, the dental implant has not fully joined with the surrounding bone. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5A1	The long-term prognosis of a restoration must be considered. Under our guidelines, a fixed partial denture should be retained by either all natural teeth, or all implants; not a combination of the two. Based on the consultant's professional review of the submitted information, this guideline is not met because one of the bridge retainers is anchored on a natural tooth while the other is supported by an implant. The bridge anchored this way would severely stress the natural tooth and implant and eventually would cause bone loss, mobility, and bridge failure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5A2	The long-term prognosis of a tooth must be considered. Under our guidelines, the periodontal health of a tooth to be crowned must be considered. Teeth to be crowned must not have uncontrolled or untreated periodontal disease. Based on the consultant's professional review of the submitted information, this guideline is not met because there is excessive loss of bone support which has weakened support to the tooth/teeth so that the success of the service is very questionable. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

5A3	The long-term prognosis of a tooth must be considered. Under our guidelines, an allowance for crowns or retainer crowns will not be considered on teeth in which the pulp of the tooth is infected or damaged by decay. This guideline is not met because, based on the consultant's professional review of the submitted information, the nerve of the tooth appears to be infected or damaged by decay. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5B0	Under our guidelines, a fixed partial denture replacing multiple missing teeth must be attached to enough retainers to provide adequate support. This guideline is not met	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	because, based on the consultant's professional review of the submitted information the bridge is attached to a tooth/teeth that does not provide adequate support. The bridge attached this way would severely stress this tooth and eventually cause bone loss, tooth mobility and bridge failure. The long-term success for this procedure is questionable. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5B1	This service is not a benefit of the enrollee's program because the filling, crown or bridge that has been placed is made of a temporary material which has a very short service life. Delta Dental does not allow	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	benefits for any procedure that has a less than a favorable prognosis. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays".						
5B2	This service is not a benefit of the enrollee's program because the purpose of one of the procedures is to raise the gum tissue height while the purpose of the other procedure is to lower the tissue height. The combined results of the two procedures have a projected opposite result and are therefore questionable. We can not benefit any procedure that has a less than a favorable prognosis. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays".	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5B3	Under our guidelines, the status of an endodontically treated tooth must be considered. When determining a benefit allowance for restorative services, the existing endodontic treatment must	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	be free of unresolved pathology. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because the tooth has unresolved periapical or periradicular pathology. A crown, fixed bridge, or removable bridge will not be successful because of the poor condition of the existing root canal. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5B4	The long-term prognosis and status of an endodontically treated tooth must be considered. Under our guidelines, root canal therapy should be performed with a biologically acceptable, non-	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	resorbable, semi-solid or solid core material; a restoration is not benefited on a tooth with biologically unacceptable material. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met because the existing root canal has been filled with an unsuitable material. A crown, fixed bridge, or removable bridge will not be successful because of the poor condition of the existing root canal. We do not allow benefits for any procedure that has a less than favorable prognosis. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						

5B5	When more bridge pontics are provided than is customary, the additional pontics are not covered benefits of the enrollee's program. The patient is responsible for the amount indicated as "patient pays".	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
5BR	Under our guidelines, we will benefit for replacement of missing natural teeth using the normal number of retainers for the span. When more bridge retainers are provided than is customary, the additional retainers are not covered benefits of the enrollee's program. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the extra retainer is more than customary. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5BU	According to our guidelines, the fee for buildups are included in the fee for the completed restoration, unless there is extensive loss of tooth structure (50 percent or more) as evidenced by radiographic images. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the radiograph(s) do not demonstrate significant loss of tooth structure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5C2	The long-term prognosis of a tooth must be considered. Under our guidelines,	N10 - Adjustment based on the findings of a review organization/professional	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to	PR	PI	DENY	3

	treatment is not allowed on teeth with unresolved periradicular pathology. For this service to be covered the tooth must not have any unresolved periradicular pathology. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the tooth has unresolved periapical or periradicular pathology. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	consult/manual adjudication/medical advisor/dental advisor/peer review.	the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5C3	The long-term prognosis of a tooth must be considered. Under our guidelines, there must be enough healthy bone remaining to support the tooth after placement of a restoration. Based on the dental consultant's	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	professional review of the submitted documentation, this guideline is not met because there is not enough healthy bone to support the tooth. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5C4	Under our guidelines, to qualify for crown a tooth must demonstrate significant loss of tooth structure (greater than 50%) including loss, or undermining, of a cusp or incisal angle. These guidelines are not met because, based on the consultant's professional review of the submitted information, the tooth does not demonstrate significant loss of tooth structure. Please refer to Section Four of the Dentist Handbook for	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	the guidelines and requirements for this procedure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5D0	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. Please submit a narrative concerning the prognosis, periodontal support, endodontic status, restorability, and expected length of service. Please submit a new claim or pre-treatment estimate or new predetermination with this information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

	processing, please do not attach a copy of this EOB to the new claim.						
5D1	Dentegra's allowance is based on the dental consultant's evaluation of the treatment performed.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5D2	The long-term prognosis of a tooth must be considered. Under our guidelines, for this service to be a benefit there must be adequate remaining tooth structure to allow for placement of a restoration. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the tooth has excessive loss of the tooth structure above the gum-line, which will not allow for adequate restoration. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5D3	The long-term prognosis of a tooth must be considered. Under our guidelines, endodontic treatment is not allowed on teeth with a fracture of the clinical crown that may preclude successful restoration of the tooth. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because the tooth has a crack that is unlikely to heal after endodontic treatment. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

5D4	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit recent periapical x-ray(s) that are mounted and dated. Duplicate x-rays must be dated and marked to indicate the enrollee's right and left. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N40 - Missing radiology film(s)/image(s).	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1
5D5	Dentegra's allowance reflects a fee deduction for a related procedure that was previously processed. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N357 - Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	N/A	N/A	N/A	PAY	N/A
5D7	Benefits decision delayed: The Plan cannot make a benefit decision without all	N682 - Missing/Incomplete/Invalid	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	reasonably necessary information. The provider must submit a narrative confirming the restorability of this tooth and indicating if surgical crown lengthening may be needed. Surgical crown lengthening (D4249) is not a covered service in the enrollee's contract under Schedule A. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	history of prior periodontal therapy/maintenance.					
5D8	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The need for the submitted crown is under review. The provider must submit narrative describing what was wrong with the old restoration and why it needs to be replaced	N683 - Missing/Incomplete/Invalid prior treatment documentation.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1

	by this new restoration. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5DA	This service is not a benefit of the enrollee's program because the implant has not fully attached to the surrounding bone. This results in a very unstable base for an implant-supported crown, bridge, partial or full denture.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5DB	This service is not a benefit of the enrollee's program because the bridge replacing multiple missing teeth is attached to a tooth that does not provide adequate support. The bridge attached this way would severely stress this tooth and eventually cause bone loss, tooth mobility and bridge failure. The long	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	term success for this procedure is very questionable, and Dentegra does not allow benefits for any procedure that has a less than a favorable prognosis (chance of success). Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."						
5DC	This service is not a benefit of the enrollee's program because one of the bridge supports is anchored on a natural tooth while the other is supported by an implant. The bridge anchored this way would severely stress the natural tooth and implant and eventually would cause bone loss, mobility and bridge failure. The long term success for this procedure is very questionable, and Dentegra does not allow benefits for any procedure that has a less than a favorable prognosis (chance of success). Contracting providers agree to charge the patient only the amount indicated as "Patient Pays".	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

5DD	This service is not a benefit of the enrollee's program because the filling, crown or bridge that has been placed is made of a temporary material which has a very short service life. Dentegra does not allow benefits for any procedure that has a less than a favorable prognosis (chance of success). Contracting providers agree to charge the patient only the amount indicated as "Patient Pays".	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5DE	This service is not a benefit of the enrollee's program because the excessive loss of bone support has weakened the tooth/teeth so that the success of the service is very questionable. Dentegra does not allow benefits for any procedure that has a less than a favorable prognosis (chance of success). Contracting providers agree to charge the patient only the amount indicated as "Patient Pays".	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5DF	This service is not a benefit of the enrollee's program because the purpose of one of the procedures is to raise	N10 - Adjustment based on the findings of a review organization/professional consult/manual	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PR	PI	DENY	3

	the gum tissue height while the purpose of the other procedure is to lower the tissue height. The combined results of the two procedures have a projected opposite result and are therefore questionable. Dentegra does not benefit any procedure that has a less than a favorable prognosis (chance of success). Contracting providers agree to charge the patient only the amount indicated as "Patient Pays".	adjudication/medical advisor/dental advisor/peer review.	Segment (loop 2110 Service Payment Information REF), if present.				
5DG	This service is not a benefit of the enrollee's program because the tooth in question has a severe infection of the tissue surrounding the tooth. This infection has resulted in the formation of an abscess. The success rate for a tooth with an unresolved infection is very questionable. Dentegra does not allow benefits for any procedure that has a less than favorable prognosis (chance of success). Contracting providers agree to charge	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	the patient only the amount indicated as "Patient Pays".						
5DH	The long-term prognosis of a tooth must be considered. Under our guidelines, for this service to be a benefit there must be adequate remaining tooth structure to allow for placement of a restoration. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the tooth has excessive loss of the tooth structure above the gum-line, which will not allow for adequate restoration. We do not allow benefits for any procedure that has a less than favorable prognosis. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330;	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	Sacramento, CA 95899-7330.						
5DI	The endodontic prognosis of a tooth must be considered. Under our guidelines, a crown or retainer crown is not allowed on a tooth with untreated or unresolved periapical or periradicular pathology. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the involved tooth has unresolved periapical pathology. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5DJ	The endodontic prognosis of a tooth must be considered. Under our guidelines, a crown or retainer crown is not allowed on a tooth with	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PR	PI	DENY	3

	untreated or unresolved periapical or periradicular pathology. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the involved tooth has unresolved periapical pathology. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	advisor/dental advisor/peer review.	Segment (loop 2110 Service Payment Information REF), if present.				
5DK	The periodontal health of a tooth to be crowned must be considered. Under our guidelines, teeth to be crowned must not have uncontrolled or untreated periodontal disease. Based on the consultant's professional review of the submitted information, this guideline is not met because there is excessive loss of	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	bone support which has weakened support to the tooth/teeth so that the success of the service is very questionable. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5DL	The long-term prognosis of a tooth must be considered. Under our guidelines, endodontic treatment is not allowed on teeth with a fracture of the clinical crown that may preclude successful restoration of the tooth. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because the tooth has a crack that is unlikely to heal after endodontic treatment. If you wish to request a	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5DM	The long-term prognosis and the status of an endodontically treated tooth must be considered. Under our guidelines, the placement, density and/or depth of the existing root canal filling material should provide an adequate seal. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because the placement, density and/or depth of the existing root canal filling material may not prevent an infection or other problems from occurring. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5DN	The long-term prognosis of a tooth must be considered. Under our guidelines, for a tooth to qualify for endodontic treatment there must be adequate tooth structure remaining to place a final restoration. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the amount of tooth structure available will not adequately hold a crown/restoration after the endodontic treatment is completed. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5DO	Under our guidelines, root canal therapy should be performed with a biologically acceptable, non-resorbable, semi-solid or solid core material. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the root canal has been obturated with an unsuitable material. We do not allow benefits for any procedure that has a less than favorable prognosis. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

5E3	The long-term prognosis and the status of an endodontically treated tooth must be considered. Under our guidelines, the placement, density and/or depth of the existing root canal filling material should provide an adequate seal. Based on the dental consultant's professional review of the submitted documentation these guidelines are not met because the placement, density and/or depth of the existing root canal filling material may not prevent an infection or other problems from occurring. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
5F0	Under our guidelines, to qualify for osseous surgery	M129 - Missing/incomplete/invalid	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do	PI	PI	DENY	2

	(D4260/D4261) the teeth must demonstrate 5 to 8 mm pockets with moderate to severe bone loss evident on radiographs. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because the teeth do not demonstrate moderate to severe bone loss. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	indicator of x-ray availability for review.	not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5F1	Benefits could not be determined because the rendering provider/dental office is on Focused Review and requires additional information. Please submit a new claim or pre-treatment estimate with: 1. Dated, current, diagnostic, pre-operative radiographs	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PR	PI	DENY	2

	and 2. Dated copy of your original clinical treatment notes indicating submitted procedure(s), diagnosis, protocols, materials, type & amount of anesthesia if applicable. Failure to submit ALL the necessary documentation may result in delay of payment or estimate. To ensure faster processing, please do not attach a copy of the explanation of benefits to the new claim or pre-treatment estimate.		Service Payment Information REF), if present.				
5F2	Benefits could not be determined because the rendering provider/dental office is on Focused Review and requires additional information. Please submit a new claim or pre-treatment estimate with: 1. Dated, current, diagnostic, pre-operative radiographs, 2. Dated, current periodontal charting, 3. Dated copy of the appointment schedule depicting name & time services were rendered, and 4. Dated copy of your original clinical treatment	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	notes indicating submitted procedure(s), diagnosis, protocols, materials, type & amount of anesthesia if applicable. Failure to submit ALL the necessary documentation may result in delay of payment or estimate. To ensure faster processing, please do not attach a copy of the explanation of benefits to the new claim or pre-treatment estimate.						
5F3	The long-term prognosis of a tooth must be considered. Under our guidelines, for a tooth to qualify for endodontic treatment there must be adequate tooth structure remaining to place a final restoration. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the amount of tooth structure available will not adequately hold a crown/restoration after the endodontic treatment is completed. If you wish to request a reevaluation of this action, use the Provider	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	150 - Payer deems the information submitted does not support this level of service.	PR	PI	DENY	3

	Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5F4	Benefits could not be determined because the rendering provider/dental office is on Focused Review and this service requires radiographs. Please submit a new claim with dated, diagnostic radiographs to: Delta Dental Professional Review Department P.O. Box 2108 Mechanicsburg, PA 17055-2108. Failure to submit claims and pre-treatment estimates for services subject to focused review to this PO Box will result in delay of payment.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
5F5	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with: 1.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	PI	PI	DENY	2

	Dated, current, diagnostic, pre-operative radiographs, 2. Dated, current periodontal charting, 3. Dated copy of the appointment schedule depicting name & time services were rendered, and 4. Dated copy of your original clinical treatment notes indicating submitted procedure(s), diagnosis, protocols, materials, type & amount of anesthesia if applicable. Failure to submit ALL the necessary documentation may result in delay of payment or estimate. To ensure faster processing, please do not attach a copy of the claim statement to the new claim or pre-treatment estimate.		Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5F6	Under our guidelines, services to replace/stabilize tooth structure that is lost as a result of any type of wear, including, but not limited to: attrition, erosion, abrasion and abfraction are not covered. Based on the dental consultant's professional review of the submitted documentation	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PR	PI	DENY	2

	these guidelines are not met because the tooth structure appears to be lost due to wear. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		Service Payment Information REF), if present.				
5F7	The submitted documentation does not support the payment of benefits for the procedure. This service does not meet the guidelines outlined in the Dentist Handbook. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
5F8	Under our guidelines, to qualify for periodontal scaling and root planing the teeth to be treated must have at least 4-6 millimeter probing pocket depths and radiographic evidence of at	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	PR	PI	DENY	2

	least early bone loss. Based on the dental consultant's professional review of the submitted documentation these guidelines are not met because there is no evidence of sufficient bone loss to qualify for scaling and root planing. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5F9	Under our guidelines, to qualify for a crown, at least 50% of the tooth structure must be lost due to decay or an existing restoration that is failing. Based on the dental consultant's professional review of the submitted documentation these guidelines are not met because the existing restoration does not appear to be failing. If you wish to	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5FA	Under our guidelines, anterior cantilever fixed bridges will be considered for benefit allowance only if no more than one pontic is used. Based on the dental consultant's professional review of the submitted documentation this guideline is not met because there is more than one pontic. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330;	N643 - The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.	PR	PR	DENY	3

	Sacramento, CA 95899-7330.						
5FB	Under our guidelines, posterior fixed bridges generally require the use of two retainer crowns. A posterior cantilever bridge must have more than two retainers. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because there are not two retainers. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N643 - The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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.	PR	PR	DENY	3
5FC	Under our guidelines, posterior fixed bridges generally require the use of two retainer crowns. A posterior cantilever bridge must have more than two retainers and the numbers	N643 - The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	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	PR	PR	DENY	3

	of retainers must exceed the numbers of pontics. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the number of retainers does not exceed the number of pontics. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
5FD	Under our guidelines, to qualify for osseous surgery (D4260/D4261) the teeth must demonstrate 5 to 8 mm pockets with moderate to severe bone loss evident on radiographs. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the teeth do not demonstrate 5 to 8 mm	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	pocket depths. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5FE	Under our guidelines, to qualify for periodontal scaling and root planing the teeth to be treated must have at least 4-6 millimeter probing pocket depths and some evidence of early bone loss. Based on the dental consultant's professional review of the submitted documentation these guidelines are not met because the teeth to be treated do not have at least 4-6 millimeter probing depths. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5G1	Under our guidelines, to qualify for mucogingival surgery there must be 1 mm or less of attached tissue. Based on the dental consultant's professional review of the submitted documentation, this service does not meet the guideline for mucogingival surgery of 1 mm or less of attached tissue. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
5G2	Under our guidelines, prefabricated crowns are a benefit to restore teeth in cases where there is	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At	PR	PI	DENY	2

	extensive tooth structure loss and incisal edge or cuspal involvement due to: extensive decay on multiple surfaces, pulpal therapy, or fracture. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met because the tooth does not exhibit extensive loss of tooth structure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5G3	Under our guidelines, root canal therapy should be performed with a biologically acceptable, non-resorbable, semi-solid or solid core material. Based on the dental consultant's professional review of the submitted documentation,	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	150 - Payer deems the information submitted does not support this level of service.	PR	PI	DENY	3

	this guideline is not met because the root canal has been obturated with an unsuitable material. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5G4	Under our guidelines, a surgical extraction requires a soft tissue incision, flap reflection, appropriate removal of soft and/or osseous (bone) tissue and/or sectioning of the tooth, complete removal of the tooth and roots, and closure of the surgical site. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met because the extraction did not require a soft tissue incision or flap reflection. If	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5G5	Under our guidelines, a surgical extraction requires the removal of bone and/or sectioning of tooth. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met because the extraction did not require the removal of bone and/or sectioning of the tooth. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330;	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	Sacramento, CA 95899-7330.						
5G6	The extraction of an impacted tooth must meet the ADA CDT definition of completely bony, partially bony and soft tissue impactions.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
5G7	Benefits could not be determined because of missing periodontal information. The submitted periodontal chart appears to be that of a different patient. Please submit a new claim or pre-treatment estimate with a current and dated periodontal charting for this patient, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

5G8	Benefits could not be determined because of missing information. Radiographs were received, however it appears to be that of a different patient. Please submit a new claim or pre-treatment estimate with a current and dated radiographs for this patient, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2
5G9	Under our guidelines, to qualify for benefits for a post and core the endodontically treated tooth must have insufficient tooth structure to support a restoration. There must be radiographic evidence of at least 50 percent of tooth structure missing or evidence of cuspal fracture. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	because the tooth is not missing 50 percent or more of tooth structure or have a cuspal fracture. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5GA	General Anesthesia/IV Sedation may be a covered benefit only when provided in conjunction with covered oral surgery, endodontics or periodontic procedures. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N161 - This drug/service/supply is covered only when the associated service is covered.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
5GB	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with a current periodontal chart, dated,	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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	PI	PI	DENY	2

	pre-operative diagnostic radiographs and a copy of the patient treatment record.		ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5GC	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with a current periodontal chart, dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
5GD	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with: 1. Dated, current, diagnostic, pre-operative radiographs and 2. Dated copy of your original clinical treatment notes indicating submitted procedure(s), diagnosis, protocols, materials, type & amount of anesthesia if applicable. Failure to submit ALL the necessary documentation may result	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	in delay of payment or estimate.						
5GE	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
5GF	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
5GH	Under our guidelines, to qualify for benefits for a post and core, a tooth must exhibit a successfully completed endodontic treatment. Based on the dental consultant's professional review of the	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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	PR	PI	DENY	2

	submitted documentation, these guidelines are not met because the tooth does not have a successfully completed endodontic treatment. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5GI	Under our guidelines, to qualify for a post and core, a tooth must exhibit a successfully completed endodontic treatment. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met because the tooth does not have a successfully completed endodontic treatment. It appears the tooth has untreated or unresolved periapical or	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	2

	periradicular pathology. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5GJ	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with a dated copy of your original clinical treatment notes indicating submitted procedure(s), diagnosis, protocols, materials, type & amount of anesthesia if applicable. Upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PI	DENY	1
5H6	Limitation applies as listed in Evidence of Coverage: A stayplate is a benefit only	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PR	PR	DENY	3

	when used as an anterior space maintainer for a child.	information about restrictions for this service.	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.				
5H7	Limitation applies as listed in the Evidence of Coverage: The benefit is for non-precious metal only. The use of a noble or high noble precious metal is optional.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5HD	Our records indicate this patient has a history of dentures, this procedure is not a benefit when performed on a patient with a history of dentures. The patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3
5HS	Benefits decision delayed: This service(s) requires proof and date of prior placement. Please submit a new claim or pre-treatment estimate with documentation providing the prior placement date or verification that this is the initial placement of the denture and/or partial denture, upon receipt we	N333 - Missing/incomplete/invalid prior placement date.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	2

	will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5L0	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The patient's periodontal status and treatment plan are under review. The provider must submit recent full-mouth periodontal charting showing mobility, areas of recession, six-point pocket probing and date(s) of probing. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N682 - Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1

5L1	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit recent full mouth series of periapical and bitewing x-ray(s), which are mounted and dated. If not available, indicate why not. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N681 - Missing/Incomplete/Invalid full arch series.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
5L2	Benefits decision delayed. The Plan cannot make a benefit decision with out all reasonably necessary information. This includes a provider narrative. It should state why each soft tissue graft is needed and describe any soft tissue defects. Recent periodontal charting is also necessary. Six-point probing and any mobility	N711 - Incomplete/invalid summary.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1

	must be charted. For each tissue graft site, the millimeters of recession and the width of the keratinized gingiva are needed. If available, the provider should submit an intra-oral photograph of each graft site. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5L3	The plan cannot make a benefit decision without all reasonably necessary information. An alveoloplasty was submitted in conjunction with a surgical extraction, a procedure which includes minor bone re-contouring. The provider must resubmit with a narrative explaining scope of the bone re-contouring performed and why it was needed for	N20 - Service not payable with other service rendered on the same date.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	reconsideration. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5L4	The plan cannot make a benefit decision without all reasonably necessary information. An Incision & Drainage (I&D) was submitted in conjunction with an extraction, a procedure which generally establishes drainage. The provider must resubmit with a narrative describing why a separate I&D was needed for reconsideration. Please submit a new claim or pre-treatment estimate or new pre determination with correct and complete information, upon receipt we will process the submitted service(s) in	N20 - Service not payable with other service rendered on the same date.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	accordance with our processing guidelines.						
5L5	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The reason for frenectomy is under review. The provider must submit current x-ray(s) and a narrative describing the frenum's location and reason(s) for treatment. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	processing, please do not attach a copy of this EOB to the new claim.						
5L6	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a copy of chart documentation that evidences chronic pain associated with this specific tooth. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N716 - Missing chart.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1
5L7	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit recent full-mouth series of periapical and bitewing x-ray(s), which are mounted and dated. If not available, indicate why	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	not. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5L8	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a dated pre-operative periapical x-ray. Duplicate x-rays must be dated and marked to indicate the enrollee's right and left. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

5L9	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a dated pre-operative periapical x-ray. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N40 - Missing radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
5M0	For processing purposes, a dental consultant has revised the procedure code because submitted documentation supported that a different procedure code was appropriate. To be considered a surgical extraction or an impaction, a tooth must meet the definition for these services as described in the CDT nomenclature and descriptor.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

5M1	For processing purposes, a dental consultant has revised the procedure code because submitted documentation supported that a different procedure code was appropriate.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5M2	Dental coding updated: Based upon the description of the service provided, and/or the submitted documentation, a consulting dentist has updated the procedure code for processing purposes.	N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PR	PR	DENY	4
5M3	Limitation applies as listed in Evidence of Coverage: If a covered service can meet the same dental need as a non-covered/optional alternative service, then the covered service must be available for copayment. The fee for a non-covered/optional alternative is equal to the copayment for the covered service plus the difference between that dentist's normal fees for the two services.	N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PR	PI	DENY	4
5MA	Under our guidelines, incomplete endodontic treatment is not a benefit.	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims	PI	PI	DENY	2

	Incomplete filling and sealing of the canals can lead to recurrent infection. Based on the dental consultant's professional review of the submitted documentation, these guidelines are not met because the placement, density and/or depth of the root canal filling material is incomplete and may not prevent an infection or other problems from occurring. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5MB	Under our guidelines, incomplete endodontic treatment is not a benefit. Incomplete filling and sealing of all the canals in the root can lead to recurrent infection. Based	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	PI	PI	DENY	2

	on the dental consultant's professional review of the submitted documentation, this guideline is not met because main or accessory canals are not completely cleaned and/or obturated. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5MC	The long-term prognosis and the status of an endodontically treated tooth must be considered. Under our guidelines, the placement, density and/or depth of the root canal filling material should provide an adequate seal. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the root canal filling	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	material extends beyond the apex into the attachment apparatus. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5MD	Under our guidelines, benefits for endodontic treatment are not allowed on teeth that demonstrate perforation(s). If there is a perforation in the root of the tooth, the seal may not be effective and lead to recurrent infection, or persistent symptoms. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the tooth/root has a perforation that cannot be adequately sealed. If you wish to request a reevaluation of this action,	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5ME	Under our guidelines, incomplete endodontic treatment is not a benefit. An instrument or obstruction in the root and used to clean the root can prevent an adequate seal and lead to recurrent infection, or persistent symptoms. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because there is an instrument or other natural obstruction in the root that has prevented an adequate seal. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5R0	The above procedure(s) was reviewed by licensed dentist Beth Gavren, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5R1	The above procedure(s) was reviewed by licensed dentist Michael Cogan, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
5R2	The above procedure(s) was reviewed by licensed dentist Jason Francis, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5R3	The above procedure(s) was reviewed by licensed dentist Hanh Nguyen, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

5R4	The above procedure(s) was reviewed by licensed dentist Aida Safai, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5R5	The above procedure(s) was reviewed by licensed dentist Christopher Choi, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5R6	The above procedure(s) was reviewed by licensed dentist Dain Paxton, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5R7	The above procedure(s) was reviewed by licensed dentist Jeffrey Peifer, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5R8	The above procedure(s) was reviewed by licensed dentist Kary Berry, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

		advisor/dental advisor/peer review.					
5R9	The above procedure(s) was reviewed by licensed dentist Marcello Indelicato, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RA	The above procedure(s) was reviewed by licensed dentist Afton Cowen, DMD, 015519GA, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RB	The above procedure(s) was reviewed by licensed dentist Bruce Katz, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RC	The above procedure(s) was reviewed by licensed dentist John Fox, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RD	The above procedure(s) was reviewed by licensed dentist Christopher Morin, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PI	PI	DENY	3

		adjudication/medical advisor/dental advisor/peer review.	Segment (loop 2110 Service Payment Information REF), if present.				
5RE	The above procedure(s) was reviewed by licensed dentist Erika Sibbie, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RF	The above procedure(s) was reviewed by licensed dentist Peter Drake, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RG	The above procedure(s) was reviewed by licensed dentist Douglas Miller, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RH	The above procedure(s) was reviewed by licensed dentist Anthony Pacenta, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RI	The above procedure(s) was reviewed by licensed dentist	N10 - Adjustment based on the findings of a review organization/professional	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to	PI	PI	DENY	3

	John Gale, DMD, (1-415-974-8698).	consult/manual adjudication/medical advisor/dental advisor/peer review.	the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5RJ	The above procedure(s) was reviewed by licensed dentist Glenn Poch, DDS, 31033PA, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RK	The above procedure(s) was reviewed by licensed dentist Victor Maya, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RL	The above procedure(s) was reviewed by licensed dentist Anthony Vlahiotis, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RM	The above procedure(s) was reviewed by licensed dentist Jonathan Staker, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RN	The above procedure(s) was reviewed by licensed dentist	N10 - Adjustment based on the findings of a review	50 - These are non-covered services because this is not deemed a 'medical	PI	PI	DENY	3

	Leigh Westee, DDS, (1-415-974-8698).	organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5RO	The above procedure(s) was reviewed by licensed dentist Lee Weinstein, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RP	The above procedure(s) was reviewed by licensed dentist Julie Cha, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RQ	The above procedure(s) was reviewed by licensed dentist Jessica Drapcho, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RS	Our records indicate history of a restoration within twelve-months, crown, inlay/onlay or fixed prosthodontic procedure may be allowed upon on a request for re-evaluation, with a deduction of fee for	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3

	original restorative service. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
5RT	The above procedure(s) was reviewed by licensed dentist Carol Wong, DDS, MS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RU	The above procedure(s) was reviewed by licensed dentist Eric Neuer, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RV	The above procedure(s) was reviewed by licensed dentist Ernest Borgards, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

5RW	The above procedure(s) was reviewed by licensed dentist Richard Bulleri, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RX	Benefits could not be determined because the submitted radiograph does not depict the entire tooth. Please submit a new claim or pre-treatment estimate with dated, diagnostic quality, pre-operative periapical radiograph images depicting the apex, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
5RY	The above procedure(s) was reviewed by licensed dentist Albert Cu, DDS, (1-475-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5RZ	The above procedure(s) was reviewed by licensed dentist	N10 - Adjustment based on the findings of a review	50 - These are non-covered services because this is not deemed a 'medical	PI	PI	DENY	3

	Andrew Krantz, DDS,DS024393L-PA, (1-415-974-8698).	organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5S0	The above procedure(s) was reviewed by licensed dentist Michael Tarighati, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5S1	The submitted documentation was reviewed by a dental consultant. The consultant has applied an allowance for an alternate oral surgery procedure based on the anatomical position of the tooth. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
5S2	This procedure was previously processed or is a duplicate of another procedure on this claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5S4	This procedure was previously processed or is a	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	duplicate of another procedure on this claim.	information about restrictions for this service.	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.				
5S5	The above procedure(s) was reviewed by licensed dentist Michia Johnson Harris, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5S6	The above procedure(s) was reviewed by licensed dentist Patrick McDevitt, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5S7	The above procedure(s) was reviewed by licensed dentist Sahar Sepidehdam, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5S8	The above procedure(s) was reviewed by licensed dentist Suzanne Saie, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

5S9	The above procedure(s) was reviewed by licensed dentist Teresita Harm, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5SA	The above procedure(s) was reviewed by licensed dentist Aamir Sheikh, DDS, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5SB	The above procedure(s) was reviewed by licensed dentist Daniel Spagnoli, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5SC	The above procedure(s) was reviewed by licensed dentist Andrea Csonka, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
5SD	The above procedure(s) was reviewed by licensed dentist Franklin "Chip" Price, DMD, (1-415-974-8698).	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

		advisor/dental advisor/peer review.					
5SP	Enrollee's plan offers specialty care at a 25% discount, the enrollee's portion is 75% of the provider's fee.	N/A - N/A	131 - Claim specific negotiated discount.	PR	PR	PEND	N/A
5T1	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. A panoramic x-ray or duplicate film was submitted without the date made and marks to indicate the enrollee's "left" and "right". Provider must submit again with a dated x-ray or film that is properly marked. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N40 - Missing radiology film(s)/image(s).	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1
5T2	Benefits decision delayed: The plan cannot make a benefit decision without all	N40 - Missing radiology film(s)/image(s).	252 - An attachment/other documentation is required to adjudicate this claim/service. At least one Remark	PI	PI	DENY	1

	reasonably necessary information. The provider must submit pre-operative panoramic x-ray. A duplicate film must be dated and marked to indicate the enrollee's right and left. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).				
5T3	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit periapical x-rays showing the tooth both before and after treatment. Submitted x-rays must be dated and marked "Pre-op" or "Post-op". Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt	N40 - Missing radiology film(s)/image(s).	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1

	we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5T4	To avoid possible capitation deduction, assigned dentist must forward immediately to periodontist recent full-mouth x-rays (D0210/D0277).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5T5	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph does not adequately depict the tooth. The provider must submit a narrative confirming the tooth number and periapical film showing the tooth. Claims for completed endodontic services must be submitted with periapicals made before and after treatment. Submitted radiographs must be dated and marked "Pre-op" or	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	"Post-op". Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5T6	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph does not adequately depict the tooth. The provider must submit a narrative confirming the tooth number and periapical film showing the tooth. Claims for completed endodontic services must be submitted with periapicals made before and after treatment. Submitted radiographs must be dated and marked "Pre-op" or "Post-op". Please submit a new claim or pre-treatment estimate with correct and complete information, upon	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5T7	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph does not adequately depict the tooth/teeth. The provider must submit a narrative confirming the tooth number and periapical or panoramic radiograph(s). Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
5T8	Benefits decision delayed: The plan cannot make a	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was	PI	PI	DENY	1

	benefit decision without all reasonably necessary information. Bitewing and other radiographs that do not depict the apex of the tooth are inadequate for this procedure. The provider must submit periapical or panoramic radiograph(s). Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		incomplete or deficient. The necessary information is still needed to process the claim. 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).				
5T9	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph(s) is not diagnostic. The provider must submit additional radiograph(s) that adequately depict the tooth/teeth and are free of stains, streaks, fogging, distortion or other defects,	N242 - Incomplete/invalid radiology film(s)/image(s).	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	which would compromise diagnostic quality. Bitewing and other radiographs that do not depict the apex of the tooth are inadequate. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5U0	Benefit is limit: Surgically accessing of an unerupted tooth only covered for permanent tooth, but is not covered for a third molar.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5U2	Benefit is limited: Must be done in conjunction with a new denture or partial denture fabrication.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

5U3	Benefit is limited: Intraoral incision and drainage of abscess-soft tissue (D7510) is covered for all ages. Extraoral incision and drainage - soft tissue (D7520) is not covered by Delta Dental, but may be covered by the UDOH Medicaid Fee-for-Service program through 20 years of age NOTE: Medicaid does not cover complicated intraoral or extraoral incision and drainage (D7511 and D7521).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5U4	Benefit is limited. Medicaid covers tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus (D7270). It does not cover intentional reimplantation (D3470) or tooth transplantation (D7272).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5U5	Benefit is limited: General dentists may be reimbursed for extractions, incision and drainage, and frenulectomies. Some oral surgery codes are only payable to an oral surgeon.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

5U6	Exclusion applies: Medicaid does not cover charges for laboratory tests or pathology reports, (The laboratory or pathologist must bill the charges directly to Medicaid.)	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5U7	Exclusion applies: Medicaid does not cover ridge augmentation.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5U8	Exclusion applies: Medicaid does not cover osteotomies.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5U9	Exclusion applies: Medicaid does not cover vestibuloplasty.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UA	Benefit is limited: D9221 can only be billed in conjunction	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	with covered general anesthesia (D9220).	information about restrictions for this service.	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.				
5UB	Benefit is limited: Provider must submit copy of the patient's records documenting a physical or mental disability or other condition which necessitates use of I.V. Sedation. Anxiety does not qualify as a medical condition. Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. Sedation.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UC	Benefit is limited: Must be billed in conjunction with covered I.V. Sedation (D9241).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UD	Benefit is limited: Is covered for intramuscular and non-intravenous conscious sedation only includes the	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.)	PI	PI	DENY	3

	sedative drug through the UDOH.		Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5UE	Exclusion applies: Medicaid does not cover behavior management (D9920), nitrous oxide analgesia (D9230) or oral sedation (D9630). However, oral sedation medications are covered under the Medicaid pharmacy program by prescription only	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UF	Benefit is limited: This Plan only covers emergency services, which are performed in a dental office by a general dentist, dental specialist, or oral/maxillofacial surgeons.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UG	Benefit is limited: Covered dental emergency services are limited to the treatment of an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

5UH	Exclusion applies: Medicaid does not cover house calls	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UI	Exclusion applies: Medicaid does not cover consultation or second opinions not requested by Medicaid or expressly authorized by the Plan.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UJ	Exclusion applies: Medicaid does not cover generating or processing claim forms	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UK	Exclusion applies: Medicaid does not cover services which require a prior authorization and are provided before the prior authorization is given. However, this exclusion does not apply to a dental emergency service, which is limited to the treatment of	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

	an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.						
5UL	Pre-operative periapical x-ray(s) required to pre-authorize this service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UM	Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth. For permanent supernumerary teeth use 51 - 67. For primary supernumerary teeth use AS - KS.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UN	Benefit is limited : This service is not covered for Medicaid members who are covered as pregnant adults.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UO	Medicaid members may choose to upgrade a	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	covered service to a non-covered service if they assume the responsibility for the difference between the provider's usual and customary fees for the non-covered service and the covered service. However, the only dental procedures they may choose to upgrade are: 1. A covered stainless steel crown (D2931) to non-covered porcelain or cast noble/high-noble/gold crown; 2. A covered anterior stainless steel crown (D2930) to non-covered anterior stainless steel crown with a tooth-colored facing); or 3. Another covered dental procedure when authorized by the dental plan or through a hearing process.	information about restrictions for this service.	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.				
5UP	Generally, a provider may not bill a Medicaid patient for the difference between the Medicaid payment and the provider's usual and customary fee, as the Medicaid payment is considered payment in full. The provider cannot mandate nor insist the	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

	covered procedure be upgraded. However, when a patient requests a non-covered service, a provider may ONLY bill the Medicaid patient when ALL FOUR of the following conditions are met: 1. The Provider has an established policy for billing all Enrollees for services not covered by a third party. (The charge cannot be billed only to Medicaid patients.) 2. The Enrollee is advised prior to receiving a non-covered service that Medicaid will not pay for the service. 3. The Enrollee agrees to be personally responsible for the payment. 4. The agreement is made in writing, prior to treatment, between the Provider and the Enrollee which details the service and the amount to be paid by the patient.						
5UQ	The dental plans shall identify Children With Special Health Care Needs and provide timely access to the following services: a. Comprehensive evaluation for the condition. b.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	Pediatric subspecialty consultation and care appropriate to the condition. c. Rehabilitative services provided by professionals with pediatric training. d. Durable medical equipment appropriate for the condition. e. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
5UR	The definition of children with special health needs includes, but is not limited to 1. Nervous System Defects; 2. Craniofacial Defects; 3. Complex Skeletal Defects; 4. Inborn Metabolic Disorders; 5. Neuromotor Disabilities; 6. Congenital Heart Defects; 7. Genetic Disorders; 8. Chronic Illnesses (such as Cystic Fibrosis, Hemophilia, Rheumatoid Arthritis, Bronchopulmonary Dysplasia, Cancer, Diabetes, Nephritis, Immune Disorders); and 9. Developmental Disabilities	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

	with multiple or global delays in development.						
5US	Exclusion applies: This Plan does not cover any dental service for non-pregnant adults, children who are covered by Foster Care Medicaid, or clients covered by Refugee Medicaid or Nursing Home Medicaid. Medicaid may cover these services through the Utah Department of Health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UT	Exclusion applies: This Plan does not cover facility charges for hospital and ambulatory surgical centers. Medicaid may cover these services through the Utah Department of Health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UU	Exclusion applies: This Plan does not cover medical and surgical services of a dentist, including general anesthesia performed at a hospital or ambulatory surgical center. Medicaid may cover these services through the Utah Department of Health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UV	Exclusion applies: This Plan does not cover services performed at an Indian Health Services (IHS), tribal	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	facility or an Urban Indian Facility (UIF). Medicaid may cover these services through the Utah Department of Health.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5UW	Exclusion applies: This Plan does not cover services performed at the state hospital or state developmental center. Medicaid may cover these services through the Utah Department of Health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UX	This Medicaid member is assigned to a local Delta Dental facility. Covered services, which are within the scope of a general dentist, are covered in that assigned facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UY	Exclusion applies: This Plan does not cover emergency services provided in an emergency department (ED) of a hospital or an urgent care facility. Medicaid may cover these services through the Utah Department of Health.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
5UZ	Benefit is limited: Code D9440 is only allowed for use for visits occurring after the regular business day (8	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	a.m. to 5 p.m.), typically in connection with an emergency appointment. If an appointment is scheduled in the course of normal business procedures, it is not allowed under this code. This includes lunch, afternoon breaks, and visits after normal hours when the dentist sees the patient following the normal closing hour. This code may be used only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which cannot be scheduled. Scheduled appointments are not allowed reimbursement under this code. Provider must submit copy of patient's record documenting time and the emergency.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5WC	This procedure was previously processed. If this is a request for reconsideration it must be	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	submitted through the appeal process. Please submit this request for reconsideration to Quality Management/QM600, Delta Dental of California, P.O. Box 6050 Artesia, CA 90702 as directed.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
5X2	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The prognosis and/or treatment plan is under review. The provider must submit a treatment plan and narrative concerning prognosis, restorability and expected longevity. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1
5X3	Benefits decision delayed: The plan cannot make a benefit decision without all	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	reasonably necessary information. There appears to have been a related traumatic injury. The provider must submit a narrative indicating the date and nature of that traumatic injury. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5X4	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a narrative confirming the tooth number(s), the nature of the treatment, whether the treatment was completed and, if so, the date completed. Please submit a new claim or pre-treatment estimate with correct and complete information, upon	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5X5	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. Payment is pending an itemized statement from the treating dental facility. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1
5X6	Benefits decision delayed: Additional documentation was not received after a previous request for information. For reconsideration, the	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	provider must submit the additional documentation so that the plan can make a benefit decision. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5X7	Benefits could not be determined because the submitted procedure code is not recognized. Please submit a new claim or pre-treatment estimate with complete itemized procedure information, including a valid procedure code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

5X8	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The enrollee's periodontal status and treatment plan are under review. The provider must submit the results of recent full-mouth periodontal charting showing pocket depths at least three weeks after completion of scaling and root planing. Also, indicate the dates of each quadrant root planing and scaling. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1
5X9	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. When two or more quadrants of osseous	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	surgery (D4260) are submitted with the same date of service, the provider must submit narrative describing the circumstances. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5Y1	Limitation applies as listed in Evidence of Coverage: For a crown or fixed bridge with porcelain over metal, having its margin at the gum line covered with porcelain can cost up to $75 more per tooth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Y2	Limitation applies as listed in Evidence of Coverage: For a molar, a tooth-colored inlay, onlay, crown or fixed-bridge can cost up to $150 more per tooth over the copayment for one that is metallic.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

5Y3	Payment of claim under Accidental Injury Rider.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Y4	After reconsideration, an alternative allowance has been made based on the covered benefit (PDRM).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Y5	Limitation applies as listed in Evidence of Coverage: For enrollees through the age of three (3), benefits provided by a pediatric dentist are covered and copayment applies.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Y6	Limitation applies as listed in Evidence of Coverage: If elected by the enrollee, a "high noble" metal crown, onlay, inlay or cast post and core can cost up to $100 over the copayment for a "base" or "noble" metal alternative.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

5Y7	The allowable benefit(s) were applied to your group annual deductible.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Y8	Limitation applies as listed in the Evidence of Coverage: For emergency services provided outside the assigned facility, the Plan will reimburse up to $400 minus applicable copayment(s).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Z0	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The provider must submit a radiograph of the opposing tooth/teeth. If not available, a narrative identifying the opposing natural teeth and describing their condition may be submitted alternatively. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
5Z2	Dental coding updated: A consultation is a diagnostic service by a practitioner who is not otherwise providing treatment. The submitted consultation code has been updated to one for an examination.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Z7	Limitation applies as listed in Evidence of Coverage: For e are available for copayment. However, this coverage is subject to a $500 calendar year maximum. After the plan has paid a total of $500 during the year, there is no coverage for additional services by a pediatric dentist for the rest of that year.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
5Z9	The provider must submit a copy of the biopsy report when submitting for payment.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1
630	According to our guidelines, the allowance for this procedure was included in	M15 - Separately billed services/tests have been bundled as they are	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been	PR	PI	DENY	4

	the fee for the original appliance. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	considered components of the same procedure. Separate payment is not allowed.	adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
632	According to our guidelines, a posterior fixed partial denture is not a covered benefit when a previous allowance has been provided for a removable partial denture in the same arch. This service is not covered because our claim history shows a removable partial denture in the same arch. Please refer to Section Four of the Dentist Handbook for dental policy and guidelines for periodontal surgical procedures. If you wish to request a re-evaluation of this action, please submit a copy of the claim detail section of the payment summary, copies of x-rays, photos and/or clinical comments. Submit this information to the same address and PO Box as the original claim or pre-treatment estimate.	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3

633	According to our guidelines, a removable partial denture is not a covered benefit when a previous allowance has been provided for a posterior fixed bridge in the same arch. The patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
634	The replacement of a tooth extracted prior to the patient's effective date of coverage is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
635	The enrollee's program has a missing tooth limitation. Therefore, an allowance has been applied for the bridge abutment(s) based on the consultant's professional review of the submitted information. The patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
636	Limitation applies as listed in Evidence of Coverage: Replacing a congenitally missing tooth is not a benefit. Similarly, replacing a primary tooth, which was	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	retained, is also not a benefit.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
637	Our records show this provider is not enrolled and credentialed. This service is only a covered benefit when the enrollee is treated by a credentialed provider.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
638	The fee for an immediate denture or partial denture includes any adjustments, relines, or tissue conditioning within 3 months of delivery. A separate fee is not billable to the patient.	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3
639	The fee for full or partial dentures include any adjustment, repair, relines, or tissue conditioning required within six months of delivery. A separate fee is not billable to the patient.	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3
640	The fee for implant removal is not separately allowed if performed within 3-months of surgical implant placement. A separate fee is not billable to the patient.	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3

693	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for routine services performed outside the assigned facility. A routine, general practice, dental procedure is covered within the assigned facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6A1	Our records show you are not an active provider in the Delta Dental State Government programs and/or, the service office indicated is not enrolled in the program or, the service office ID number is incorrect. Please e-mail provider_ services@delta.org for assistance.	N277 - Missing/incomplete/invalid other payer rendering provider identifier.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	2
6CO	Delta Dental is unable to process this claim because the provider has opted-out of Medicare and agreed to provide covered services to Medicare enrollees only through private contract. The patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
6CP	We cannot pay for this service because the billing	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PI	DENY	3

	provider has opted out of Medicare and agreed to provide covered services to Medicare enrollees only through a private contract with the enrollee.	information about restrictions for this service.	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.				
6CS	We cannot authorize or pay for this service because the provider is on the U.S. Department of Health and Human Services Office of Inspector General (OIG) exclusions list. We are required to deny payment for any health care service you provide during the time period that you are included on the exclusion list.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6CT	We cannot authorize or pay for this service because the billing provider is on the U.S. Department of Health and Human Services Office of Inspector General exclusions list. We are required to deny payment for any health care service you provide during the time period that you are included on the exclusion list.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6E1	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary	N706 - Missing documentation.	148 - Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be	PR	PR	DENY	N/A

	information. The provider must state whether this is the initial placement or a replacement. If a replacement, the plan also needs the age of existing and why it must be replaced instead of repaired or adjusted. Please submit a new claim or pre-treatment estimate or new pre determination with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.		comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)				
6MA	Eight (8) posterior natural or prosthetic teeth (molars and/or bicuspids) in occlusion (four (4) maxillary and four (4) mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests will be reviewed for necessity based upon the presence/absence of eight (8) points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact). Services cannot be	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

	authorized unless there are at least eight points of contact.						
6MB	Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
6MC	If the total number of teeth which require, or are likely to require treatment would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
6MD	Full and/or partial dentures are only covered when they are required to alleviate a serious health condition or one that affects employability.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

		advisor/dental advisor/peer review.					
6ME	The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the mouth in those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
6MF	The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the mouth in those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
6MG	In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3

6MH	The fabrication of a fixed bridge is generally considered for members with no recent caries activity (no initial restorations placed during the past year), no unrestored carious lesions, no significant periodontal bone loss in the same arch and no posterior tooth loss with replaceable space in the same arch.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
6MJ	The fabrication of a fixed bridge is generally considered for members with no recent caries activity (no initial restorations placed during the past year), no unrestored carious lesions, no significant periodontal bone loss in the same arch and no posterior tooth loss with replaceable space in the same arch.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
6MK	The fabrication of a fixed bridge is generally considered for members with no recent caries activity (no initial restorations placed during the past year), no unrestored carious lesions,	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3

	no significant periodontal bone loss in the same arch and no posterior tooth loss with replaceable space in the same arch.						
6ML	All carious teeth must be restored before placement of any space maintainer. The member should be practicing a sufficient level of oral hygiene to ensure that the space maintainer will not become a source of further carious breakdown of the dentition. All permanent teeth in the area of space maintenance should be present and developing normally.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
6MP	When any portion of a treatment plan requires prior approval, the complete treatment plan listing all necessary procedures, whether or not they require prior approval, must be listed and coded on the prior approval request form. Any completed treatment which is not evident on submitted images should be noted. No treatment other than provision of symptomatic relief of pain	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

	and/or infection is to be instituted until such time as cases have been reviewed and a prior approval determination made.						
6N6	Exclusion applies as listed in Evidence of Coverage: There is no coverage for dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized Dental Specialist, or a Contract Orthodontist except for emergency services as described in the Contract and/or Evidence of Coverage.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
6NS	Our records show this provider is not a specialist. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N95 - This provider type/provider specialty may not bill this service.	242 - Services not provided by network/primary care providers.	PI	PI	DENY	3
6OF	The Office of Foreign Assets Control (OFAC) enforces economic sanctions against parties engaged in activities that are deemed a threat to economy or security of the United States. We cannot authorize or pay for this service because the provider is under OFAC Sanction.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

6OT	The Office of Foreign Assets Control (OFAC) enforces economic sanctions against parties engaged in activities that are deemed a threat to economy or security of the United States. We cannot authorize or pay for this service because the provider is under OFAC Sanction.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6PC	We cannot authorize or pay for this service because the provider is on the Centers for Medicare and Medicaid (CMS) preclusion list and is not allowed to receive payment for Medicare services. We are required to deny payment for any health care service you provide during the period that you are on the preclusion list.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6PT	We cannot authorize or pay for this service because the billing provider is on the is on the Centers for Medicare and Medicaid (CMS) preclusion list and is not allowed to receive payment for Medicare services. We are required to deny payment for any health care service you provide during	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

	the period that you are on the preclusion list.						
6SE	We cannot authorize or pay for this service because the provider is on a state list of excluded providers and is not allowed to receive payment for Medicare or Medicaid services. We are required to deny payment for any health care service you provide during the period that you are on the state list of excluded providers.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6SF	The billing provider is excluded from participation in the Medicaid program. We cannot authorize or issue payment for any service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
6SL	We cannot authorize or pay for this service. The provider or billing office is excluded from participating in Medicare and Medicaid because they are under exclusion by the Federal Government System for Award Management (SAM) procurement system.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3

6SM	The General Service Administration System for Award Management office (SAM) maintains a database of parties excluded from Federal procurement activities. We cannot authorize or pay for this service because the provider is on the SAM database of excluded individuals.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
702	Limitation applies as listed in Evidence of Coverage: General anesthesia and / or intravenous sedation analgesia benefits are limited to treatment by a contracted oral surgeon in conjunction with an approved referral for the removal of one or more partial or full bony impactions (procedures D7230, D7240 & D7241).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
703	This service is not a covered benefit for the tooth number submitted. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PR	DENY	3
707	Limitation applies as listed in Evidence of Coverage:	N30 - Patient ineligible for this service.	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	There is a history of four other quadrants of scaling and root planing (deep cleaning) for the enrollee. Based upon how frequently this service is covered on the enrollee's plan, this scaling and root planing is not a benefit.		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.				
708	The fee for the replacement of a prefabricated crown by the same dentist or dental office within 24 months is included in the fee for the initial crown placement. A separate fee is not billable to the patient.	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3
709	Our records indicate this patient has a history of a prefabricated crown on the same tooth. This procedure is not a benefit when performed on a tooth with a history of crown within 24-months. A separate fee is not billable to the patient.	N30 - Patient ineligible for this service.	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.	PR	PI	DENY	3
70L	Limitation applies as listed in Evidence of Coverage: If an existing denture can be made serviceable by adjustment, repair, relining or rebasing, there is no benefit for its replacement	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3

70X	Limitation applies as listed in Evidence of Coverage: If the existing partial denture is less than five years old, a new partial is only covered when it is the only way to replace a permanent tooth that was recently removed.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PR	DENY	3
71E	Limitation applies as listed in Evidence of Coverage: For permanent teeth, a pulpotomy (removing part of a tooth's nerve) is covered to offer relief. Afterwards, root canal therapy is usually needed.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
71F	Limitation applies as listed in Evidence of Coverage: Relines or rebases are limited to one per arch in any 12 month period.	M90 - Not covered more than once in a 12 month period.	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.	PI	PI	DENY	3
71S	Exclusion applies as listed in Evidence of Coverage: Procedures to treat either lip lesions or salivary gland pathology are not listed as covered services in the enrollee's contract under Schedule A. An enrollee who agrees to have such	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	procedures performed is responsible for the fees.						
71U	Benefit is limited to two per calendar year per provider, or one per calendar year per provider in addition to a comprehensive oral evaluation (D0150).	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
71X	Limitation applies as listed in Evidence of Coverage: There is a history of the same service being provided for the enrollee. Based upon how frequently this service is covered on the enrollee's plan, it is not a benefit.	M80 - Not covered when performed during the same session/date as a previously processed service for the patient.	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.	PR	PI	DENY	3
720	Need/Appropriateness: The plan has not received all reasonable information necessary to determine the benefit for this procedure. We need a recent, diagnostic x-ray, and a narrative. The narrative must describe treatment of the tooth to date, the ability to restore the tooth, and chances for success (prognosis). Please submit a new claim or pre-treatment estimate with correct and complete information, upon	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

	receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
721	Under our guidelines, treatment or removal of a primary tooth is not covered when the tooth is about to be shed or lost naturally. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the tooth is ready to exfoliate naturally. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
722	Limitation applies as listed in Evidence of Coverage: For	N129 - Not eligible due to the patient's age.	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	children up to age 13, benefits provided by a pediatric dentist are covered and copayment applies.		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.				
724	A panoramic film is a benefit for individuals ages 6 and older. The patient is responsible for the amount indicated as "Patient Pays."	N129 - Not eligible due to the patient's age.	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.	PR	PI	DENY	3
725	Vertical Bitewings are not allowable within 60-days of an intraoral complete series of radiographic images by the same dentist/dental office. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N129 - Not eligible due to the patient's age.	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.	PR	PI	DENY	3
726	The placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is considered part of the extraction and/or post-operative procedure. A separate fee is not billable to the patient.	N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PR	PI	DENY	4
727	The enrollee's program has a limitation of once in a two-year period for this service.	M86 - Service denied because payment already made for same/similar	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

	This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	procedure within set time frame.					
729	The enrollee's program has a limitation of once in a five-year period for this service. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
72C	Limitation applies as listed in Evidence of Coverage: For a primary tooth that needs a crown, the benefit is for a stainless steel crown. If another type of crown is done, it would be an elective service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
72D	To qualify for post and core in addition to crown coverage, a tooth must demonstrate significant loss of tooth structure (greater than 50%). Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N661 - Documentation does not support that the services rendered were medically necessary.	P21 - Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies. 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	PR	PI	DENY	3

			REF qualifier 'IG') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.				
72F	The fee for frenulectomy or frenuloplasty is included in the fee for surgical procedure(s) in the same surgical area by the same dentist/dental office on the same date of service.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
72M	Exclusion applies as listed in Evidence of Coverage: A consultation or other procedure is not covered when solely done to evaluate or facilitate another non-covered service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
72S	Under our guidelines, incision and drainage is covered only when the necessary to reduce an infection. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the removal of the tooth would generally	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4

	establish adequate drainage without the need for a separate surgical incision. Neither the plan nor enrollee is responsible for any separate fee for incision and drainage. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
72U	Benefit is limited to one time only per provider	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PR	DENY	3
72X	Limitation applies as listed in Evidence of Coverage: There is a history of a bleaching in the same dental arch. Based upon how frequently this service is covered on the enrollee's	N640 - Exceeds number/frequency approved/allowed within time period.	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	PR	PR	DENY	3

	plan, this bleaching is not a benefit.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
735	Under our guidelines, to qualify for crown or fixed partial denture retainer coverage: an anterior tooth must demonstrate significant loss of tooth structure (greater than 50%) and involvement of one or both incisal angles or, in the instance of a cuspid, involvement of the tip of the cusp. A posterior tooth must have significant missing tooth structure (greater than 50%) including loss of, or undermining of, one or more cusps, and a compromised mesial or distal marginal ridge. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the radiograph(s) do not demonstrate significant loss of tooth structure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
736	To qualify for crown or fixed partial denture retainer coverage: an anterior tooth must demonstrate significant loss of tooth structure (greater than 50%) and involvement of one or both incisal angles or, in the instance of a cuspid, involvement of the tip of the cusp. a posterior tooth must have significant missing tooth structure (greater than 50%) including loss of, or undermining of, one or more cusps, and a compromised mesial or distal marginal ridge.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
737	Need/Appropriateness: A fixed bridge is not covered in the back of the mouth if the pontic (artificial tooth) is supported only on one side (cantilevered).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

738	Under our guidelines, for a restoration to be covered a tooth must have decay, a failing prior restoration, or otherwise missing tooth structure (not due to wear or attrition). Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the radiograph(s) does not demonstrate decay, a failing restoration or significant loss of tooth structure. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
73M	Exclusion applies as listed in Evidence of Coverage: There is no coverage for treatment needed because of an accidental injury, except as specified in the enrollee's	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	contract in an Accidental Injury Rider.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
73U	Benefit is limited: Medicaid will reimburse for only one evaluation (D0140, D0120, or D0150) per patient per day, even if more than one provider is involved from the same office or clinic. Multi-exams for the same date of service are not covered.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
73X	Exclusion applies as listed in Evidence of Coverage: This procedure is subject to an applicable plan limitation or exclusion.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
740	Need is not apparent: The plan already approved an earlier request for the same specialty service. There is no apparent need for this consultation. If t here is additional information regarding the need for this service, please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
741	The plan cannot make a benefit decision without all reasonably necessary information. All necessary information was not received after a previous request for information. For reconsideration, the provider must submit a new request with all necessary x-rays and records. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
742	Only one recementation or re-bonding of a space maintainer is allowed per arch.	N640 - Exceeds number/frequency approved/allowed within time period.	273 - Coverage/program guidelines were exceeded.	PR	PR	DENY	3

743	The member has met the annual contractual maximum. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
745	The patient's lifetime benefit for this treatment has been reached. You may use our online provider Tools for eligibility and benefits information, including remaining maximums and deductibles. The patient is responsible for the amount indicated as "Patient Pays."	N45 - Payment based on authorized amount.	35 - Lifetime benefit maximum has been reached.	PR	PR	DENY	3
748	Only one recementation or re-bonding of a space maintainer is allowed per quadrant.	N640 - Exceeds number/frequency approved/allowed within time period.	273 - Coverage/program guidelines were exceeded.	PR	PR	DENY	3
74U	Benefit is limited: 1. Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. 2. Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
750	Exclusion applies as listed in Evidence of Coverage: There is no coverage to replace	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PR	PR	DENY	3

	lost or stolen dentures, space maintainers, crowns or bridges.	information about restrictions for this service.	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.				
751	Maximum applies: Your group's coverage is subject to an annual maximum. No additional payments above that maximum can be approved.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
752	Maximum applies: The Accidental Injury Rider is subject to a maximum. No additional payments above that maximum can be approved.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
757	The patient exceeds the program's age limit for this procedure. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N129 - Not eligible due to the patient's age.	6 - The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
758	According to the enrollee's program, this service is a covered benefit only after the patient has reached a specified age. The patient is responsible for the amount indicated as "Patient Pays."	N129 - Not eligible due to the patient's age.	6 - The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

759	Exclusion applies as listed in Evidence of Coverage: The patient exceeds the Plan's age limit for this procedure.	N129 - Not eligible due to the patient's age.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
75S	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for routine services performed outside the assigned facility. The routine removal of teeth and exposed roots is performed and covered within the assigned facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
75T	Exclusion applies as listed in Evidence of Coverage: The patient does not meet the Plan's age limit for this procedure.	N129 - Not eligible due to the patient's age.	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.	PR	PR	DENY	3
75U	Benefit is limited: Panoramic x-rays and full series x-rays shall not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient's records.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
76E	Exclusion applies as listed in Evidence of Coverage: Apexification, apexogenesis	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PR	PR	DENY	3

	and recalcification procedures are not listed as a covered service in the enrollee's contract under Schedule A, therefore they are not included as covered benefits. An enrollee who agrees to have one of these services performed is responsible for its fee.	information about restrictions for this service.	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.				
76M	Exclusion applies as listed in Evidence of Coverage: There is no coverage for hospitalization, outpatient surgery centers, extended care facilities, or other similar facilities.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
76U	Benefit is limited: X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal procedure.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
76X	Exclusion applies as listed in Evidence of Coverage: This procedure is subject to an applicable plan limitation or exclusion.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3
77U	Benefit is limited to members 16 through 20 years of age.	N129 - Not eligible due to the patient's age.	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	PR	PR	DENY	3

			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.				
77X	Limitation applies as listed in Evidence of Coverage: There is a history of a previous set of full-mouth x-rays for the enrollee. Based upon how frequently this service is covered on the enrollee's plan, this set is not a benefit.	M90 - Not covered more than once in a 12 month period.	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.	PR	PR	DENY	3
781	The enrollee's program has a limitation of once in a five-year period for this service. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
782	The enrollee's program has a limitation of once in a seven-year period for this service. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

	the amount indicated as "Patient Pays."						
783	The enrollee's program limits this service to twice only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
784	The enrollee's program limits this service to three times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
785	The enrollee's program limits this service to four times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
789	The fee for a crown/inlay/veneer repair completed within 24 months of the original restoration is included in the fee for the original restoration. Please refer to Section Four of the Dentist Handbook for dental policy and guidelines for crown repairs. Contracting	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	providers agree to charge the patient only the amount indicated as "Patient Pays."						
78A	The enrollee's program limits this service to five times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
78B	The enrollee's program limits this service to six times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
78C	The enrollee's program limits this service to ten times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
78D	The enrollee's program limits this service to 12 times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
78E	The enrollee's program limits this service to 24 times only. Because the	M86 - Service denied because payment already made for same/similar	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

	service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	procedure within set time frame.					
78F	The enrollee's program limits this service to 36 times only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
78M	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. This specialty referral requires documentation from the patient's medical history supporting why the procedure(s) is not possible to perform at the assigned facility. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

78S	Dental coding updated: the fee for electronic enrollee monitoring during general anesthesia or deep sedation is considered to be included as part of that service. Neither the plan nor enrollee is responsible for any separate fee for monitoring.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
78U	Benefit is limited to two per calendar year.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PI	PI	DENY	3
78X	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for routine services performed outside the assigned facility. Routine root canal therapy is performed and covered within the assigned facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
790	Limitation applies as listed in Evidence of Coverage: The benefit for tooth bleaching covers only one bleaching tray per arch and a two-weeks' supply of	N640 - Exceeds number/frequency approved/allowed within time period.	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	PR	PR	DENY	3

	bleaching gel for self-treatment.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
795	Need/Appropriateness: To be covered, this service needs to have a favorable chance of success, the service is not appropriate. In this case, the chance of success is not favorable.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
796	Exclusion applies as listed in Evidence of Coverage: There is no coverage to diagnose TMJ problems or to treat them by altering the biting surfaces of an enrollee's teeth (equilibration), splints, nightguards or other means.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
79M	Exclusion applies as listed in Evidence of Coverage: Prior authorization for this procedure was approved at a contracted specialist. Procedures completed at a non-contracted facility are not covered.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
79U	Benefit is limited: A prophylaxis, with or without fluoride, is covered two times a calendar year per provider for children through age 18. For pregnant women, only the prophylaxis is covered.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PR	DENY	3

7A1	The enrollee's program excludes prescription drugs. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7A2	According to our guidelines, emergency palliative treatment of dental pain includes all related services with the exception of required radiographic images or select diagnostic procedures and it is not a separate benefit if other services are performed on the same visit. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	N20 - Service not payable with other service rendered on the same date.	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.	PR	PI	DENY	3
7A3	According to our guidelines, the fee for routine post-operative visits are considered part of, and included in the fee for, the total surgical procedure. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M144 - Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
7A4	According to our guidelines, the fee for occlusal	N130 - Consult plan benefit documents/guidelines for	97 - The benefit for this service is included in the payment/allowance for another	PR	PI	DENY	4

	adjustments of recently completed appliances or restorations are considered to be part of, and included in the fee for, the completed service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	information about restrictions for this service.	service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7A5	Exclusion applies as listed in Evidence of Coverage: There is no coverage for antibiotics, pain medication or other drugs and medicines unless considered to be a component part of a covered dental procedure, as performed in a dental office.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7BB	This service is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7BC	The member is enrolled for the Dentegra Discount plan which is a discount plan and not an insurance product. The member is responsible	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	for 100% of the provider's accepted fee.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7BL	This service is a covered benefit. It is subject to a frequency limitation, procedure conflict rule, age limitations, or other type of benefit limitation that has been applied. Please refer to the Dentist Handbook for more information.	N30 - Patient ineligible for this service.	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.	PI	PI	DENY	3
7BX	Limitation applies as listed in Evidence of Coverage: There is a history of a previous set of bitewing x-rays for the enrollee. Based upon how frequently this service is covered on the enrollee's plan, this set is not a benefit.	M90 - Not covered more than once in a 12 month period.	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.	PR	PR	DENY	3
7C0	Limitation applies as listed in Evidence of Coverage: Treatment or removal of a primary tooth is not covered when the tooth is about to be naturally shed or lost.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7C1	The submitted procedure is not payable due to the absence or conflict of a related service that is in our records for this patient. Please refer to Section 4 of	N376 - Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.	22 - This care may be covered by another payer per coordination of benefits.	PR	PR	DENY	3

	the Dentist Handbook for information regarding dental policy and clinical guidelines for this service.						
7C2	The submitted procedure is not payable due to the absence or conflict of a related service that is in our records for this patient. Please refer to Section 4 of the Dentist Handbook for information regarding dental policy and clinical guidelines for this service.	M80 - Not covered when performed during the same session/date as a previously processed service for the patient.	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.	PR	PI	DENY	3
7C3	According to our guidelines, this procedure cannot be submitted for a pre-treatment estimate.	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PI	PI	DENY	3
7C4	The submitted procedure is not payable due to the absence or conflict of a related service that is in our records for this patient. Please refer to Section 4 of the Dentist Handbook for information regarding dental policy and clinical guidelines for this service.	N376 - Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.	22 - This care may be covered by another payer per coordination of benefits.	PR	PR	DENY	3
7C5	The submitted procedure is not payable due to conflict of a related service. Please refer to Section 4 of the Dentist Handbook for information regarding	N376 - Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.	22 - This care may be covered by another payer per coordination of benefits.	PR	PI	DENY	3

	dental policy and clinical guidelines for this service.						
7CB	The enrollee's program limits this service to once only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."	N117 - This service is paid only once in a patient's lifetime.	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.	PI	PI	PDMD	3
7CD	The enrollee's program has a limitation of once in a five-year period for this service. This service has already been provided within the frequency period, therefore a new service cannot be benefited. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	PDMD	3
7CM	El procedimiento presentado no se puede pagar debido a conflicto con un servicio relacionado. Los proveedores contratantes acuerdan cobrarle al paciente solo el monto indicado como "El paciente paga".	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
7CS	This service has exceeded the program's frequency limitation, or is not listed on the Schedule of Benefits, or was performed by a	N45 - Payment based on authorized amount.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification	PR	PR	DENY	3

	Participating Specialist and therefore qualified for a discount, which was applied. The patient is responsible for the amount indicated as "Patient Pays."		Segment (loop 2110 Service Payment Information REF), if present.				
7D1	Under our guidelines, this service is covered to maintain space after a primary tooth is lost prematurely. If there is no need to maintain space, this service is not covered. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the radiograph(s) does not demonstrate a need to maintain a space for the erupting permanent tooth (teeth). If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330;	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3

	Sacramento, CA 95899-7330.						
7D2	Under our guidelines, this service is covered when it is needed to keep the space open after a primary tooth is lost prematurely. If the primary tooth/teeth have been missing for an extended period and more than 50% of the original space is already lost this service may not be covered. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the radiograph(s) does not demonstrate adequate space for the erupting permanent tooth (teeth). If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

7D3	Under our guidelines, this service is covered only when it is necessary to maintain space for the permanent tooth to erupt. It is not covered if eruption of the permanent tooth or teeth is very near or already occurring. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the permanent tooth is already erupting. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7D5	Limitation applies as listed in Evidence of Coverage: The enrollee exceed the programs age limitation for this procedure if sealants are placed on a permanent first or a second molar that	N30 - Patient ineligible for this service.	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	PR	PR	DENY	3

	has no decay or existing filling.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7D6	Exclusion applies as listed in Evidence of Coverage: There is no coverage for consultation, appliances or other treatment by specialists in either pediatric dentistry or orthodontics.	N30 - Patient ineligible for this service.	26 - Expenses incurred prior to coverage.	PR	PR	DENY	3
7D9	Limitation applies as listed in Evidence of Coverage: For enrollees through the age of seven (7), benefits provided by a pediatric dentist are covered and copayment applies.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PR	DENY	3
7DC	The member is enrolled for the Dentegra Discount plan which is a discount plan and not an insurance product. The member is responsible for 100% of the provider's accepted fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7DP	The fees for this procedure is included in the fee for any other surgical procedure(s) on the same date, same surgical site/area, by the same dentist/dental office. Contracting providers agree to charge the patient only	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3

	the amount indicated as "Patient Pays."						
7E1	According to our guidelines, therapeutic pulpotomy is a benefit only on primary teeth. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4
7E3	Claim form incomplete, submit tooth number(s) for teeth to be treated. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7E4	Limitation applies as listed in Evidence of Coverage: For enrollees through the age of six (6), benefits provided by a pediatric dentist are covered and copayment applies.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7E5	The plan cannot make a benefit decision without all	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	reasonably necessary information. There is insufficient documentation to authorize this specialty care referral without a supporting narrative. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
7E6	Limitation applies as listed in Evidence of Coverage: The Accidental Injury Rider only covers treatment provided within 180 days following the date of the related traumatic injury.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7E8	A dental specialist treated this tooth/area. The enrollee can return to the same specialty facility for related routine follow-up/recall, which is available at no additional cost to patient or the Plan.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

7E9	Need/Appropriateness: The plan has not received all reasonable information necessary to determine the benefit for this procedure. This procedure closes the end of the tooth and is the final step in completing the root canal treatment. Provide a recent diagnostic x-ray and a narrative describing the results of the initial treatment to close the end of the root (D3351). Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N785 - Missing current radiology film/images.	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1
7ED	This service is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

7F1	The enrollee's program limits this service to a specific frequency, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
7F2	The enrollee's program limits this service to a specific frequency, which has been exceeded. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3
7F3	This service has exceeded the program's frequency limitation of once in 90 days. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
7F4	This service has exceeded the program's frequency limitation of once in 30 days. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
7F5	The enrollee's program limits this service to a specific frequency, which has been exceeded. Contracting providers agree	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

	to charge the patient only the amount indicated as "Patient Pays."						
7F6	According to our guidelines, a denture/removable partial denture is not allowed within six-months of a denture/partial denture reline procedure in the same arch. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4
7F7	According to our guidelines, a denture/removable partial denture is not allowed within 24-months of a denture/partial denture rebase procedure in the same arch. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4
7F8	Our records show the coronal portion of this tooth was previously removed. Therefore, we cannot make a benefit allowance for the requested procedure. If you have additional information to provide, you may request a reevaluation.	N117 - This service is paid only once in a patient's lifetime.	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.	PR	PI	DENY	3
7G1	The patient's annual maximum has been reached. The patient is responsible for payment of	M86 - Service denied because payment already made for same/similar	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

	services provided after the annual maximum has been reached.	procedure within set time frame.					
7H0	The requested coverage for this service is not approved. There is a limit on how many times it can be authorized. It is only covered once in six-months. That limit has already been reached. This service is not covered when the limit has already been reached.	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7H1	Exclusion applies as listed in Evidence of Coverage: The orthodontic benefit for Healthy Family enrollees is limited to medically necessary coverage under the California Children Services (CCS) program. Children who may be eligible for CCS services should be referred to the county program by their dentist. Dentists may contact DCUSA contact center at 1-866-774-5595 for a CCS referral form and guidelines.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7H2	Exclusion applies as listed in Evidence of coverage: Referral to a pediatric dentist is not covered unless	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	required due to medical necessity and the inability of the assigned general dentist to treat the child.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7H3	Exclusion applies as listed in Evidence of Coverage: There is no coverage for full mouth reconstruction (a total of five or more new inlays, onlays, crowns or units of fixed bridgework). Other covered procedures are not excluded.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7H4	The requested coverage for this service is not approved. There is a limit on how many times it can be authorized. It is only covered 3 times in one week. That limit has already been reached. This service is not covered when the limit has already been reached.	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7H5	The enrollee's program limits this service to a specific frequency of 3-times in six-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7H6	The enrollee's program limits this service to a	N435 - Exceeds number/frequency	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	specific frequency of 3-times in one year, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	approved /allowed within time period without support documentation.					
7H7	The enrollee's program limits this service to a specific frequency of 3-times, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7H8	The enrollee's program limits this service to a specific frequency of 4-times in 12-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7H9	The enrollee's program limits this service to a specific frequency of 6-times in 2-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HE	The enrollee's program limits this service to a specific frequency of once to the same dentist/dental	N435 - Exceeds number/frequency approved /allowed within	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	office, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	time period without support documentation.					
7HF	The enrollee's program limits this service to a specific frequency of once per day, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HG	The enrollee's program limits this service to a specific frequency of once in 2-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HH	The enrollee's program limits this service to a specific frequency of once 3-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HI	The enrollee's program limits this service to a specific frequency of once in six-months, which has been exceeded. Therefore, the	N411 - This service is allowed one time in a 6-month period.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	patient is responsible for the amount indicated as "Patient Pays."						
7HJ	The enrollee's program limits this service to a specific frequency of 1-times in 12-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HK	The enrollee's program limits this service to a specific frequency of once in 24-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HL	The enrollee's program limits this service to a specific frequency of once in 36-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N416 - This service is allowed 1 time in a 3-year period.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HM	The enrollee's program limits this service to a specific frequency of once in 60-months, which has been exceeded. Therefore, the patient is responsible for	N417 - This service is allowed 1 time in a 5-year period.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	the amount indicated as "Patient Pays."						
7HN	The enrollee's program limits this service to a specific frequency of once in 96-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HO	The enrollee's program limits this service to a specific frequency of once, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HP	The enrollee's program limits this service to a specific frequency of 3-times in six-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HQ	The enrollee's program limits this service to a specific frequency of twice in 1-week, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

7HR	The enrollee's program limits this service to a specific frequency of twice in six-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HS	Exclusion applies as listed in Evidence of Coverage: There is no coverage for denture or partial dentures without prior authorization.	N333 - Missing/incomplete/invalid prior placement date.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	2
7HT	The enrollee's program limits this service to a specific frequency of twice in 12-months, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HU	The enrollee's program limits this service to a specific frequency of twice in 60-months, which has been exceeded. Therefore, the patient is responsible	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3

	for the amount indicated as "Patient Pays."						
7HV	The enrollee's program limits this service to a specific frequency of twice, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
7HW	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 5-years age or older.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7HX	Limitation applies as listed in the Evidence of Coverage: Tissue conditioning benefit is limited to two per denture.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PR	DENY	3
7HY	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 6-monhts old or older. The service is not covered if the member has not reached the minimum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

7HZ	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 2-years age or older. The service is not covered if the member has not reached the minimum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7I1	According to our guidelines, the allowance for this procedure was included in the fee for the original service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PI	DENY	3
7IC	The fees for the removal of an interim implant component by the same dentist/dental office who placed the implant component are considered part of the interim abutment placement procedure and are not billable to the patient.	M80 - Not covered when performed during the same session/date as a previously processed service for the patient.	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.	PR	PI	DENY	3
7ID	Implants are not a benefit under this plan (Group #1713). If the treatment has not been approved by the ILWU-PMA Plan Office, please forward the claim to	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	N/A	PI	PI	DENY	N/A

	the ILWU-PMA Plan Office, 1188 Franklin Street, Ste. 101, San Francisco, CA 94109. ATTN: Dental implant claims. If this treatment was pre-approved by the ILWU-PMA Plan Office for payment, Delta Dental will process the claim under Group #6339 now. Payment will be made within 30 days.						
7IM	Second stage implant surgery is not a covered benefit if performed by a different dentist/dental office that performed the surgical placement of the implant.	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
7IP	This service requires review by Capital District Physicians' Health Plan. Please submit directly to CDPHP at the following address: Capital District Physicians' Health Plan Attention: UM 500 Patroon Creek Blvd Albany, NY 12206.	MA48 - Missing/incomplete/invalid name or address of responsible party or primary payer.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
7K1	According to our guidelines, the fee for this procedure is	M80 - Not covered when performed during the	97 - The benefit for this service is included in the payment/allowance for another	PR	PI	DENY	4

	considered to be part of, and included in the fee for a completed service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	same session/date as a previously processed service for the patient.	service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7L2	Exclusion applies as listed in Evidence of Coverage: This is an implant service. It is not a covered service. Therefore, we are unable to pay for this service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7L3	Exclusion applies as listed in Evidence of Coverage: For full dentures, there is no coverage for metal bases, soft-liners, porcelain teeth, personalization, attachments or overlays.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7L7	Limitation applies as listed in Evidence of Coverage: Tooth-colored fillings are covered for anterior teeth only. The benefit for posterior teeth is amalgam instead. A tooth-colored filling on a posterior tooth is an elective service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7L9	This group does not have lab reimbursement benefit.	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

		information about restrictions for this service.	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.				
7LX	Limitation applies as listed in Evidence of Coverage: A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture in the same arch. The plan benefit is a removable partial denture.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7M1	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for services performed outside the assigned facility	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	N/A	N/A	N/A	N/A
7M3	Limitation applies as listed in Evidence of Coverage: The procedure is not listed as a covered service on either Schedule A of the enrollee's contract or the Accidental Injury Rider.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7M5	Limitation applies as listed in Evidence of Coverage: If	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	the assigned provider is available, and an enrollee is within 35 miles of that provider, then, emergency services by another provider are not covered.	information about restrictions for this service.	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.				
7M7	Limitation applies as listed in Evidence of Coverage: Benefits for emergency care outside the assigned facility does not include reimbursement for routine, non-emergency, services.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7M8	Limitation applies as listed in Evidence of Coverage: After consideration of the enrollee's medical condition and "special needs," no exception is granted. The service is not covered.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7M9	Exclusion applies as listed in Evidence of Coverage: This procedure is subject to an applicable plan limitation or exclusion.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7MA	If a non-covered surgical procedure (e.g. crown lengthening, D4249) is required to properly restore	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PI	DENY	3

	a tooth, any associated restorative or endodontic treatment will NOT be considered for reimbursement.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7MB	The member has a high caries rate and therefore does not meet criteria.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	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.	PR	PI	DENY	3
7MN	This service is not a covered benefit of the enrollee's program. A dentist may not bill or collect from an enrollee any charges in connection with a dental service, even though that service is not a covered dental service unless an executed financial responsibility form has been obtained from the enrollee or the enrollee's legal representative. Please refer to the Dentist Handbook for more information.	MA48 - Missing/incomplete/invalid name or address of responsible party or primary payer.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	PDMD	2
7N6	Exclusion applies as listed in Evidence of Coverage: There is no coverage for dental services received from any dental facility other than the	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.)	PR	PR	DENY	3

	assigned Contract Dentist, a preauthorized Dental Specialist, or a Contract Orthodontist except for emergency services as described in the Contract and/or Evidence of Coverage.		Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7NB	This service is not a covered benefit of the enrollee's program. The patient is responsible for the difference between the non -covered service and the providers' fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4
7NH	This service is not a covered benefit of the enrollee's program. A dentist may not bill or collect from an enrollee any charges in connection with a dental service, even though that service is not a covered dental service unless an executed financial responsibility form has been obtained from the enrollee or the enrollee's legal representative. Please refer to the Dentist Handbook for more information.	N30 - Patient ineligible for this service.	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.	PI	PI	DENY	3
7NP	Our records indicate that you are not a participating network provider. There is	MA48 - Missing/incomplete/invalid name or address of	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims	PI	PI	PDMD	2

	no plan coverage for services performed by an out of network provider.	responsible party or primary payer.	attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7O1	Orthodontic services are not covered benefits of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7OD	Services performed outside the provider Network are not a benefit. However, emergency services may be available. Please refer to your plan benefit for coverage detail. You may contact the customer service department to discuss emergency service coverage. The patient is responsible for the amount indicated as "Patient Pays".	M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	242 - Services not provided by network/primary care providers.	PR	PR	DENY	3
7OG	According to the enrollee's program, this service is a covered benefit when the member has a history of	M83 - Service is not covered unless the patient is classified as at high risk.	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	PR	PR	DENY	3

	periodontal surgical treatment. The patient is responsible for the amount indicated as "Patient Pays."		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7OS	Services performed outside the provider Network are not a benefit. The patient is responsible for the amount indicated as "Patient Pays".	M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	242 - Services not provided by network/primary care providers.	PR	PR	DENY	3
7P1	Under our guidelines, benefits for bone replacement grafts are generally allowable when performed on vertical, multi-walled or narrow defects. Benefits may not be allowed in areas of horizontal bone loss, class III furcation involvements and broad interproximal defects. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the bone loss does not appear to be a vertical, multi-walled or narrow defect. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional	N40 - Missing radiology film(s)/image(s).	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1

	supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
7P2	Need/Appropriateness: Neither the submitted x-rays nor charting show that this is a separate surgical site. Coverage is for treatment of a single site involving multiple teeth. Neither the Plan nor the enrollee should be billed for this bone graft.	N40 - Missing radiology film(s)/image(s).	252 - An attachment/other documentation is required to adjudicate this claim/service. 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).	PI	PI	DENY	1
7P4	Exclusion applies as listed in Evidence of Coverage: Procedures, appliances or restorations when provided solely to change the vertical dimension are not covered.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7P6	Exclusion applies as listed in Evidence of Coverage: Irrigation is not listed as a "covered service" in the enrollee's contract under Schedule A. An enrollee who agrees to have this elective service performed is responsible for its fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

7P7	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for routine services performed outside the assigned facility. Root planing is routinely performed and covered within the assigned facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7P8	Exclusion applies as listed in Evidence of Coverage: Surgical crown lengthening (D4249) is not listed as a "covered service" in the enrollee's contract under Schedule A. An enrollee who agrees to have the service performed is responsible for its fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7PA	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 5-years age or older. The service is not covered if the member has not reached the minimum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7PB	The requested coverage for this service is not approved. According to the enrollee's program, this service is a	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment	PI	PI	DENY	3

	covered benefit only after the patient 6-years age or older. The service is not covered if the member has not reached the minimum age.		(loop 2110 Service Payment Information REF), if present.				
7PC	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 12-years age or older. The service is not covered if the member has not reached the minimum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7PD	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 13-years age or older. The service is not covered if the member has not reached the minimum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7PE	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 18-years age or older. The service is not covered if the member has	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

	not reached the minimum age.						
7PF	The requested coverage for this service is not approved. According to the enrollee's program, this service is a covered benefit only after the patient 21-years age or older. The service is not covered if the member has not reached the minimum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7PG	The patient exceeds the program's age limit of 20-years for this procedure. The service is not covered if the member has exceed the maximum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7PH	The patient exceeds the program's age limit of 23 for this procedure. The service is not covered if the member has exceed the maximum age.	N129 - Not eligible due to the patient's age.	9 - The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
7PI	The requested coverage for this service is not approved. This service is only a covered benefit when performed on a permanent tooth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PJ	The requested coverage for this service is not approved.	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	This service is only a covered benefit when performed on primary.	information about restrictions for this service.	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.				
7PK	The requested coverage for this service is not approved. This service is only a covered benefit when performed on a primary anterior teeth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PL	The requested coverage for this service is not approved. This service is only a covered benefit when performed on a primary molars.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PM	The requested coverage for this service is not approved. This service is only a covered benefit when performed on a permanent anterior tooth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PN	The requested coverage for this service is not approved. This service is only a covered benefit when	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	performed on permanent bicuspids.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7PO	Orthodontic installment payments automatically, subject to the patient's continued eligibility and contract maximum. Therefore, requests for periodic payments do not need to be submitted.	N390 - This service/report cannot be billed separately.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PI	PI	DENY	4
7PQ	The requested coverage for this service is not approved. This service is only a covered benefit when performed on permanent molars.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PR	The requested coverage for this service is not approved. The service is only covered on permanent first and second molars. This is not a permanent first or second molar. The service is not covered when it is requested on this tooth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PS	The requested coverage for this service is not approved. This service is only a covered benefit when	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.)	PI	PI	DENY	3

	performed on permanent bicuspids and molars.		Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
7PT	The requested coverage for this service is not approved. This service is only a covered benefit when performed on a permanent 1st bicuspid and anterior teeth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PU	The requested coverage for this service is not approved. This service is only a covered benefit when performed on primary and permanent anterior teeth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PV	The requested coverage for this service is not approved. This service is only a covered benefit when performed on bicuspids and permanent and primary molars.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7PW	The requested coverage for this service is not approved. This service is only a covered benefit when performed on permanent anterior teeth, 1st bicuspids and primary molars.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Identification Segment (loop 2110 Service Payment Information REF), if present.				
7Q1	Under our guidelines, the periodontal health of a tooth to be crowned must be considered. Teeth with uncontrolled or untreated periodontal disease typically have a compromised long-term prognosis. Based on the dental consultant's professional review of the submitted documentation, this guideline is not met because the poor periodontal prognosis of the involved tooth or teeth. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
7RM	Benefits are not payable because the maximum for the current benefit period has been reached. The patient is responsible for	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3

	the amount indicated as "Patient Pays."						
7S2	Limitation applies as listed in Evidence of Coverage: General anesthesia/intravenous sedation is only a benefit with an approved referral for removal of a tooth that is impacted and covered by bone.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7S6	Exclusion applies as listed in Evidence of Coverage: There is no coverage to re-implant, transplant, realign, or splint teeth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7S9	Exclusion applies as listed in Evidence of Coverage: Exploratory surgery is not listed as a "covered service" in the enrollee's contract under Schedule A. An enrollee who agrees to have this service performed is responsible for its fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7SN	Under our guidelines, this service is covered when the eruption of a tooth may be obstructed. Based on the dental consultant's professional review of the	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

	submitted documentation, this guideline is not met because this tooth does not appear to be impacted and it appears to have a clear path to erupt. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7SR	According to our guidelines, allowance has been previously provided for a restorative procedure. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
7U1	Benefit is limited to members aged 0 through 18 years.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

7U2	Benefit is limited: For children 18 and under, occlusal sealants on the permanent molars and pre-molars (bicuspids) are covered. D1351 is limited, per tooth, 1st or 2nd permanent molar or premolars (bicuspids) to one every two years. Sealants are available for EPSDT only clients.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7U3	Benefit is limited: Space maintainers are covered for EPSDT children 0-20 years of age.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7U4	Benefit is limited: For primary teeth, the only covered stainless steel crown is D2930. For permanent teeth, the only covered stainless steel crown is D2931.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7U5	Benefit is limited: A stainless steel crown (D2930) or D2931) cannot both be billed for the same tooth on the same date of service as an amalgam or composite	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	filling. Must bill only for the crown or the filling, but not both.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7U6	Benefit is limited: It is not allowable to bill for a build-up (D2950) with a stainless steel crown on a primary tooth (D2930). However, is allowable with a stainless steel crown on a permanent tooth (D2931).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7U7	Benefit is limited: Porcelain fused to base metal crowns (D2751) on permanent anterior teeth are covered for children through 20 years of age. Requires written prior approval.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7U8	Exclusion applies: Medicaid does not cover any crowns other than: 1. porcelain fused to base metal crown (D2751) when medically necessary to restore permanent anterior tooth; and 2. stainless steel crown (D2930 or D2931).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7U9	Benefit is limited: Stainless steel crowns (D2931), build-ups (D2950 & D2951), post and cores (D2954) are only covered for permanent	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	teeth, but are not covered for third molars.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7UA	Medicaid does not cover any crowns other than: 1. porcelain fused to base metal crown	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UB	Exclusion applies: Root canal therapy for primary teeth is excluded.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UC	Benefit is limited to permanent anterior teeth only.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UD	Benefit is limited to permanent bicuspids only.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

7UE	Benefit is limited to permanent first molars only.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UF	Benefit is limited to permanent first molars and bicuspids only.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UG	Benefit is limited to permanent first and second molars.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UH	Benefit is limited: Root canal therapy is to be billed after all canals have been completely obturated with the final filling. Complete root canal therapy is a covered service. Medicaid does not cover incomplete endodontic therapy (D3332).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

7UI	Benefit is limited to treatment of for drug-induced gingival hyperplasia only. Such as gingival hyperplasia due to the use of Dilantin or Cyclosporin.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UJ	Pre-operative periapical x-rays required to pre-authorize this service for members 0 to 17 years of age.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UK	Benefit is limited: Must have subgingival calculus present. Oral debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7UL	Benefit is limited: Must have pocket depth of 4 mm or greater. May be done once a year per quadrant.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UM	Benefit is limited: If there is an existing denture, a new	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	denture is not covered if 1. the existing can be repaired or relined for proper fit unless; or 2. the existing cannot be repaired or relined because of neglect or abuse of that denture. A denture less than five years old shall be repaired or relined.	information about restrictions for this service.	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.				
7UN	Benefit is limited: Medicaid expects prosthetic appliances to last five years. Dentures and partial denture replacements are reimbursable less than five years from the initial placement if necessitated by an extraction.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UO	Benefit is limited: Prior authorization must be obtained before removing teeth in preparation for the immediate denture. Provider must send panorex or full mouth mounted periapical x-rays.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UP	Benefit is limited: For a non-emergency, prior authorization must be obtained before fabricating the partial denture. Provider must send mounted periapical x-rays or	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	panoramic with a list of teeth to be replaced. Not covered if an existing denture can be repaired or relined when due to neglect or abuse of the existing denture.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7UQ	Benefit is limited: For an emergency involving a permanent upper anterior tooth, which has been recently avulsed or needs immediate removal because fracture or an abscess, provider may obtain telephone authorization to be followed by submittal of x-rays with the claim. However, with the claim, the provider must submit pre-operative mounted periapical x-rays or panorex with list of teeth replaced. However, a new partial denture is not a benefit if the tooth can be replaced by adding a tooth to an existing denture.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UR	Exclusion applies: Medicaid does not cover temporary partial dentures or stayplates. It also does not cover temporary or interim dentures.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Identification Segment (loop 2110 Service Payment Information REF), if present.				
7US	Benefit is limited: There must be an anterior tooth missing or the partial denture must restore mastication ability. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. However, there must be at least one posterior tooth or canine present with adequate bone support on each side of the arch.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UT	Benefit is limited: For the first six months after the delivery a new denture, the fee for routine post-delivery care and adjustments are included and may not be	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	billed by the facility, which billed for that denture.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7UU	Benefit is limited: For the first six months after the delivery an immediate denture, the fee for routine post-delivery care, adjustments and soft liners are included and may not be billed by the facility, which billed for that denture.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UV	Benefit is limited: Medicaid covers only hard relines (D5750 and D5751) completed by a laboratory. It only covers two relines per year per arch.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UW	Benefit is limited: Only covered if a clasped tooth has been extracted.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UX	Benefit is limited: Following the delivery of an immediate denture, hard relines must be delayed until bone resorption has stabilized, which would be 6	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	to 12 months following the extractions.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
7UY	Benefit is limited: An obturator prosthesis (D5931 or D5955) is open to services provided by primary children's hospital cleft palate clinic dentist.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7UZ	Exclusion applies: Medicaid does not cover dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperiosteal implants.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
7X2	The combined fees for x-rays are equal to or more than the fee for a complete x-ray series. Therefore, according to our guidelines, the x-rays are considered to be equivalent to a complete series.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7X3	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for routine services performed outside the assigned facility. Dental radiographs are routinely	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3

	performed and covered within the assigned facility.						
7X4	Limitation applies as listed in Evidence of Coverage: There is a history of another dental sealant for this tooth. Based upon how frequently this service is covered on the enrollee's plan, placing this sealant is not a benefit.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7X5	Limitation applies as listed in Evidence of Coverage: The enrollee is under the age for the crown. Crowns are not covered except for those made of stainless steel, plastic or resin.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7X6	Limitation applies as listed in Evidence of Coverage: Replacing a defective inlay, onlay, crown, fixed bridge or removable denture is not covered unless it is over three years old.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PR	DENY	3
7X7	Limitation applies as listed in Evidence of Coverage: There is a history of five or more quadrants of scaling and root planing (deep cleaning) for the enrollee within 12 months. This	M90 - Not covered more than once in a 12 month period.	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.	PR	PR	DENY	3

	scaling and root planing is not a benefit.						
7X8	Limitation applies as listed in Evidence of Coverage: Based on the plan benefit(s), the enrollee is over the age limit for coverage of specialty services by a pediatric dentist.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7X9	Limitation applies as listed in Evidence of Coverage: Replacing a defective inlay, onlay, crown, fixed bridge or removable denture is not covered unless it is over five years old.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PR	DENY	3
7XS	Pending signature of treating doctor. Signature on file is not acceptable.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
7ZI	Enrollee's plan offers a 25% discount for procedures not covered, the enrollee's portion is 75% of the provider's fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

81U	Exclusion applies: Medicaid does not cover limited orthodontic treatment, including removable appliance therapies.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
823	Exclusion applies as listed in Evidence of Coverage: Consultation, appliances and other treatment by a specialist in prosthodontics are not covered.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
826	Exclusion applies as listed in Evidence of Coverage (EOC): The EOC lists all covered services. This service is not listed. Therefore, we are unable to pay for this service.	N174 - This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	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.	PR	PR	DENY	3
828	Exclusion applies as listed in Evidence of Coverage: The enrollee's plan does not cover specialty services.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
82U	Benefit is limited: For combined	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	orthodontic/surgical cases, Medicaid requires that only a licensed orthodontic specialist and a licensed oral maxillofacial specialist be used to treat combined orthodontic/surgical cases. Delta Dental is only responsible for its listed covered services performed by the orthodontist or oral maxillofacial surgeon. Other services may be covered by the UDOH Medicaid Fee-for-Service program.	information about restrictions for this service.	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.				
831	Exclusion applies as listed in Evidence of Coverage: Neither general anesthesia nor IV sedation is listed as a "covered service" in the enrollee's contract under Schedule A.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
836	The orthodontic treatment was fully paid or completed before the patient's coverage was effective under this program. Therefore, no orthodontic benefit has been applied.	N30 - Patient ineligible for this service.	26 - Expenses incurred prior to coverage.	PR	PR	DENY	3
837	Our records indicate the enrollee has other insurance coverage; this plan is secondary when other	N4 - Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the	PR	PI	DENY	1

	coverage is available through another carrier. The other insurance carrier payment exceeds the DeltaCare liability, therefore no additional allowance has been made.		claim. 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).				
838	Exclusion applies as listed in Evidence of Coverage: Neither nitrous oxide analgesia nor sedation is listed as a "covered service" in the enrollee's contract under Schedule A. An enrollee who agrees to have either service performed is responsible for its fee.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
839	The program's orthodontic coverage does not provide benefits for retreatment or relapse cases. The patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	26 - Expenses incurred prior to coverage.	PR	PR	DENY	3
83U	Benefit is limited: Requires prior authorization at the completion of covered orthodontic treatment (D8080).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
841	Limitation applies as listed in Evidence of Coverage: The Plan's orthodontic	N30 - Patient ineligible for this service.	26 - Expenses incurred prior to coverage.	PR	PR	DENY	3

	coverage does not provide benefits for retreatment or relapse cases. The patient is responsible for these services.						
844	The repair of a fixed retainer is allowed once per lifetime to a dentist/dental office that did not place the original fixed retainer.	N117 - This service is paid only once in a patient's lifetime.	149 - Lifetime benefit maximum has been reached for this service/benefit category.	PR	PR	DENY	3
845	The fee for non-traditional methods, such as Invisalign or Incognito, is based on the approved fee for conventional orthodontics. Any additional fee for the non-traditional method is not chargeable to the patient.	N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PR	PI	DENY	4
847	Orthodontic treatment that started before the enrollee's effective date of coverage with this employer is not a benefit of the program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	26 - Expenses incurred prior to coverage.	PR	PR	DENY	3
848	Your orthodontic treatment request has been received and is in our system. There is no payment with this notice. Periodic payments will be automatically issued starting in the next payment	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4

	cycle, subject to the patient's continued eligibility and contract maximum.						
84U	Benefit is limited. If covered orthodontics was started at a different facility, the provider at the new facility must send: 1. trimmed study models and wax bite; and 2. a panorex x-ray, if there are missing/impacted teeth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
85U	Benefit is limited: The replacement of lost or broken retainer (D8692) is only covered once in a lifetime for a member who had comprehensive orthodontics (D8080) completed and covered by a Medicaid plan. Is not payable as an initial retainer.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
86U	Exclusion applies: Medicaid does not cover occlusal appliances, habit control appliances or interceptive orthodontic treatment	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
87U	Benefit is limited: General anesthesia is a covered	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PI	PI	DENY	3

	service for patients that meet age and/ or other criteria. General anesthesia for removal of erupted teeth is not a covered service, except when medically necessary.	information about restrictions for this service.	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.				
893	Exclusion applies as listed in Evidence of Coverage: Without the plan's express prior approval, there is no coverage for routine services performed outside the assigned facility. A routine, general practice, dental procedure is covered within the assigned facility.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PI	DENY	3
8AG	This Plan covers children OVER the age of 19 only. Children under age 19 may be covered under another Kaiser sponsored dental plan. If you think this claim was denied in error, contact your Kaiser Service Center at 800-464-4000 to discuss eligibility for this dependent child.	N129 - Not eligible due to the patient's age.	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.	PR	PR	DENY	3
8B0	Orthodontic limitation applies: Orthodontic x-rays, photographs, tracings, models and other orthodontic records are not covered services.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PR	PR	DENY	3

			Identification Segment (loop 2110 Service Payment Information REF), if present.				
8B1	Exclusion applies as listed in Evidence of Coverage: Interceptive (Phase I) orthodontic prior to comprehensive treatment is not a covered benefit under the enrollee's plan.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
8C1	The enrollee's plan is secondary when other coverage is available. Submit the claim to the other carrier and submit a new claim along with a copy of the explanation of benefits (EOB) from the other carrier. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
8C2	Benefit decision delayed: Unable to process claim with information provided; submit the original effective date of the other insurance carrier and indicate if it an active dental, medical or	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	retiree plan. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
8C3	Benefit decision delayed: Benefits could not be determined because of missing information on the explanation of benefits from the primary carrier. Submit the allowable fee, primary carrier's payment, description of denial/paid reason codes and patient's responsibility for each procedure submitted. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
8C5	Maximum applies: The Accidental Injury Rider is subject to a maximum of $1600. No additional payments above that maximum can be approved.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

			Identification Segment (loop 2110 Service Payment Information REF), if present.				
8D1	Orthodontic limitation applies: Comprehensive orthodontic treatment covers initial banding, de-banding and common appliances including headgear.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8D2	Orthodontic limitation applies: After 24 months of either active treatment or orthodontic retention, the enrollee can be charged up to $125 per month.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8D3	Orthodontic limitation applies: With prior approval, an enrollee can change orthodontists while in treatment; however, there can be no refunds, discounts or extension of coverage.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8D4	Orthodontic limitation applies: In addition to a copayment for interceptive or comprehensive treatment, there are fees for orthodontic start-up and retention.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

8D5	Orthodontic limitation applies: If no treatment follows a consultation, the orthodontist can charge for the consultation and any orthodontic records made.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8DA	Under the Orthodontic Takeover Provision, DeltaCare would assist our policy holder with their previous carrier's unpaid insurance benefits. The information received indicates there was no prior carrier making payments for orthodontic treatment. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8DB	Under the Orthodontic Takeover Provision, DeltaCare would assist our policy holder with their previous carrier's unpaid insurance balance. Information indicates the prior plan belonged to someone other than the DeltaCare policy holder. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

8DC	Under the Orthodontic Takeover Provision, there must be no break in coverage. Our records indicate a break in coverage. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8DD	Treatment started prior to the enrollee's effective date is subject to the Orthodontic Takeover Provision. Information received indicates prior carrier was a discount plan and monies are owed. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8DE	There is no supplemental allowance for this purchaser. Patient copayment and start-up fee represent payment in full.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8L1	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. Payment is pending for coordination of benefit statement. Please	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.		Identification Segment (loop 2110 Service Payment Information REF), if present.				
8L2	Limitation applies as listed in Evidence of Coverage: A fixed bridge is considered optional treatment, the plan benefit is a removable partial denture.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8L3	Orthodontic limitation applies: There is no coverage for active orthodontic treatment extending past 24 months.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8L4	Orthodontic limitation applies: Orthodontic retention is covered for no more than 24 months after completion of covered active treatment.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8L5	Orthodontic limitation applies: If the enrollee is	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	non-compliant and de-banded, the orthodontist can charge all applicable copayments and fees if treatment is re-started.	information about restrictions for this service.	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.				
8L6	Orthodontic limitation applies: If eligibility ends during treatment, the enrollee is financially responsible for prorated fees subject to a plan maximum.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8L7	Under the terms of the enrollee's plan benefits are calculated based on the primary carrier's contracted fees.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8L8	Benefit decision delayed: Submit the name of the person with whom the dependent resides, date of birth and effective date of other coverage. If joint custody applies, provide effective date of any other coverage. Please submit a new claim or pre-treatment estimate with correct and complete information, upon	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	receipt we will process the submitted service(s) in accordance with our processing guidelines.						
8L9	Benefits decision delayed: The plan cannot make a benefit decision without all reasonably necessary information. The submitted radiograph(s) does not depict completed root canal therapy on the submitted tooth. If root canal treatment has been completed, submit a post operative radiograph and narrative. If therapy is not complete, indicate why not, when root canal therapy will be completed and by whom. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1
8M4	Exclusion applies as listed in Evidence of Coverage: A	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	service is not covered if the dental condition is related to your employment or would otherwise be covered by Workers' Compensation.	information about restrictions for this service.	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.				
8M5	This claim was forwarded for processing under the accident injury rider clause	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8MA	Orthodontic treatment is a benefit of Child Health Plus when necessary to treat serious medical conditions such as cleft palate and cleft lip; maxillary/ mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if the child does not meet the criteria described above.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

8MB	Orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 15 points on the Handicapping Labio-Lingual Deviation (HLD) Index is required for authorization. These guidelines are not met because, per radiographs, photographs, or study models, the Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment. Orthodontic benefits are adjudicated according to our standard orthodontic processing.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
8ME	Orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 15 points on the Handicapping Labio-Lingual Deviation (HLD) Index or the existence of one of the automatic qualifying conditions is required for authorization.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3

	These guidelines are not met because per radiographs, photographs, or study models, the Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the guidelines of 15 points to qualify for orthodontic treatment.						
8MO	Orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 15 points on the Handicapping Labio-Lingual Deviation (HLD) Index or the automatic qualifying conditions of a deep impinging overbite exists. These guidelines are not met because the submitted diagnostic material does not demonstrate a deep impinging overbite causing tissue laceration and the HLD score was under 15.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	3
8MX	Exclusion applies as listed in Evidence of Coverage: For removable partial dentures, there is no coverage for precious metal, porcelain	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.)	PR	PR	DENY	3

	teeth, personalization, attachments or overlays.		Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
8NB	Orthodontic treatment must be provided by a licensed dentist. Self-administered, or any type of "do it yourself" orthodontics are not a benefit.	N665 - Services by an unlicensed provider are not reimbursable.	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.	PR	PR	DENY	3
8OD	The allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention).	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
8OE	The allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). An allowance for removal and retention is not allowed to a dentist that did not perform the orthodontic treatment.	N472 - Payment for this service has been issued to another provider.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	4
8OF	The allowances for all orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). A	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment	PR	PR	DENY	4

	replacement retainer is not a covered benefit.		(loop 2110 Service Payment Information REF), if present.				
8OG	The repair of a fixed retainer is included in the overall orthodontic case fee if performed within 24 months of placement of the fixed retainer.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
8OH	The repair of a fixed retainer is included in the overall orthodontic case fee if performed within 24 months of placement of the fixed retainer. It is not covered if performed more than 24 months after placement of the fixed retainer.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
8OJ	The application of interim caries arresting medicament is limited to a maximum of twice per tooth per year. Application on the same tooth more than twice per year are not covered.	N413 - This service is allowed 2 times in a benefit year.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
8OK	Periodic observation of patient dentition, at intervals established by the dentist, to determine when orthodontic treatment should begin is not a separate benefit when provided in conjunction with	N390 - This service/report cannot be billed separately.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4

	comprehensive orthodontic treatment.						
8OL	The limit to what we can pay for this service has already been reached. No additional benefits are available because the maximum benefit for this service has already been provided	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
8OM	Payment for braces includes putting the braces on and all the adjustments for 36 months	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
8U0	Benefit is limited: Medicaid only covers comprehensive treatment (D8080). Provider must send 1. a completed Salzmann's Index with a score 30 or more to demonstrate a handicapping malocclusion; 2. trimmed study models and wax bite, and 3. a panorex x-ray, if there are missing/impacted teeth.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8U1	Benefit decision delayed: The Plan cannot make a benefit decision without all reasonably necessary	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	information. A completed Salzmann Index was received. However, we did not receive the required trimmed orthodontic study models and wax bite with it. For further processing, please re-submit a copy of the Salzmann Index and the study models and a wax bite. If there are any missing/impacted teeth, a copy of a panoramic film or mount full series x-rays must also be submitted.						
8U2	Benefit decision delayed: The Plan cannot make a benefit decision without all reasonably necessary information. An incomplete Salzmann Index was received. For further processing, please submit a completed Salzmann Index with the trimmed orthodontic study models and a wax bite. If there are any missing/impacted teeth, a copy of a panoramic film or mount full series x-rays must also be submitted.	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1
8U3	Benefit decision delayed: The Plan cannot make a benefit decision without all	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	reasonably necessary information. A completed Salzmann Index was received. However, the measurement(s), information and/or score on the Index are not supported by orthodontic records, which were submitted with it. For further processing, please submit a revised Salzmann Index with the trimmed orthodontic study models and a wax bite. If there are any missing/impacted teeth, a copy of a panoramic film or mount full series x-rays must also be submitted.						
8U4	Benefit decision delayed: The Plan cannot make a benefit decision without all reasonably necessary information. A completed Salzmann Index was received with study models and a wax bite. However, the models show that there may be missing or impacted teeth. For further processing, please re-submit a copy of the Salzmann Index, the study models with a wax bite, and a copy	N706 - Missing documentation.	163 - Attachment/other documentation referenced on the claim was not received.	PI	PI	DENY	1

	of a panoramic film or mounted full series x-rays.						
8U5	Benefit is limited: For children under age 21, Medicaid only covers orthodontic services if there is a handicapping malocclusion due to birth defects, accidents, or abnormal growth patterns. The handicap must be such severity that it renders the child unable to masticate, digest, or benefit from their diet.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8U6	Benefit is limited: For pregnant women, Medicaid only covers orthodontic services if there is a handicapping malocclusion as a result of a recent accident or disease. The handicap must be such severity that it renders them unable to masticate, digest, or benefit from their diet.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8U7	Benefit is limited: Comprehensive orthodontic treatment (D8080) includes banding and adjustments. At the completion of treatment the provider may bill a retention code using D8680, orthodontic	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3

	retention (removal of appliance, construction and placement of retainer(s).						
8U8	Benefit is limited: This code is payable to provider type 91, which is reimbursed in the all-inclusive rate for comprehensive orthodontics (D8080). Unit limit of 36 visits without prior authorization. NOTE: Provider must have prior authorization for code comprehensive orthodontics (D8080).	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
8U9	Exclusion applies: Medicaid does not cover 1. Limited orthodontic and removable appliance therapies. 2. Removable appliances in conjunction with fixed banded treatment. 3. Habit control appliances are not a benefit. 4. Orthodontic services for cosmetic or esthetic reasons.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
8W1	The enrollee's program does not allow dual coverage. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PR	PR	N/A	3
8W2	The enrollee's program does not allow dual coverage. Therefore, the patient is	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PR	PR	N/A	3

	responsible for the amount indicated as "Patient Pays."						
8W3	The enrollee's program does not allow dual coverage. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PR	PR	N/A	3
8W4	The enrollee's program does not allow dual coverage. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PI	PI	N/A	3
8W5	The enrollee's program does not allow dual coverage. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PI	PI	N/A	3
8W6	The enrollee's program does not allow dual coverage. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	B1 - Non-covered visits.	PR	PR	N/A	3
8X0	Under our guidelines, orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum or higher score must be met on the Handicapping Labio-Lingual Deviation (HLD) Index or the existence of one of the automatic qualifying	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	conditions is required for authorization. These guidelines are not met because per radiographs, photographs, or study models, the Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the guidelines to qualify for orthodontic treatment. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
8X2	Based on our guidelines, orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score on the Salzmann Index is required for authorization. These guidelines are not met because per radiographs,	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	photographs, or study models, the Salzmann Index score does not meet the criteria to qualify for orthodontic treatment. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
8X3	Under our guidelines, orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score on the Salzmann Index is required for authorization. These guidelines are not met because, per radiographs, photographs, or study models, the Salzmann Index score does not meet the criteria to qualify for orthodontic treatment. If you wish to request a	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
8X4	Under our guidelines, orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or the automatic qualifying conditions of cleft palate must exist. These guidelines are not met because cleft palate deformities are not evident on submitted diagnostic material and the HLD score was under 26. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
8X5	Based on our guidelines orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or the automatic qualifying conditions of a deep impinging overbite exists. These guidelines are not met because the submitted diagnostic material does not demonstrate a deep impinging overbite causing tissue laceration and the HLD score was under 26. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
8X6	Under our guidelines, orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or the automatic qualifying conditions of an anterior crossbite exists. These guidelines are not met because the submitted diagnostic material does not demonstrate an anterior crossbite causing soft tissue destruction and the HLD score was under 26. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

	Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.						
8X7	Under our guidelines, orthodontic treatment is allowable only when medically necessary as evidenced by a severe handicapping malocclusion. A minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or the automatic qualifying conditions of a severe traumatic deviation must exist. These guidelines are not met because the documentation submitted does not qualify for severe traumatic deviation and the HLD score was under 26. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3

8X8	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
8X9	Orthodontic treatment requires prior authorization and diagnostic study models with bite registration or digital equivalent; cephalometric radiographic image with measurements; or panoramic radiographic image, and HLD Index (Salzmann Index in Illinois). Upon receipt of a new prior authorization request with orthodontic study models, cephalometric image, panoramic image, and HLD Index (Salzmann Index in Illinois), upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N661 - Documentation does not support that the services rendered were medically necessary.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
901	According to our guidelines, the fee for image capture is considered to be included in the fee for the	M17 - Alert: Payment approved as you did not know, and could not reasonably have been	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835	PR	PI	DENY	4

	images/radiographs. A separate fee is not billable to the patient.	expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.	Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
90E	Dental coding updated: The fee for working and final x-rays made during root canal therapy are considered to be included as part of that service. Neither the plan nor enrollee is responsible for any separate fee for such an x-ray.	M90 - Not covered more than once in a 12 month period.	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.	PI	PI	DENY	3
90H	Exclusion applies as listed in Evidence of Coverage: General anesthesia or conscious sedation is only covered if given by the DeltaCare USA provider for covered oral surgery.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
90L	Limitation applies as listed in Evidence of Coverage: If a missing tooth can be replaced by adding to an existing partial denture, a new partial denture, bridge or stayplate is not covered.	N640 - Exceeds number/frequency approved/allowed within time period.	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.	PR	PR	DENY	3

914	The assessment of salivary flow is a benefit once in 36 months.	N640 - Exceeds number/frequency approved/allowed within time period.	273 - Coverage/program guidelines were exceeded.	PR	PR	DENY	3
991	Benefits decision delayed: Processing pending for proof of payment. Please submit a new claim or pre-treatment estimate with correct and complete information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PR	PR	DENY	3
9D7	Dentegra has not received all required information from the enrollee's employer to process this claim. The enrollee should check with their Group Benefit Department prior to submitting a new claim. The patient is responsible for the amount indicated as "Patient Pays".	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
9ED	According to our guidelines, the fee for this procedure is considered to be part of, and included in the fee for a	M86 - Service denied because payment already made for same/similar	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835	PR	PI	DENY	4

	completed service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	procedure within set time frame.	Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
9EH	The fees for case management services are included in overall patient management. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3
9HH	Based on additional information/review we have reprocessed this claim to indicate the correct member liability.	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3
9MI	Benefits could not be determined because of insufficient, illegible, or missing primary coverage information. Please submit a new claim or pre-treatment estimate with an itemized copy of the denial and/or payment notification from the primary plan, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1

	processing, please do not attach a copy of this EOB to the new claim.						
9ND	Benefits could not be determined because of insufficient, illegible, or missing primary coverage information. Please submit a new claim or pre-treatment estimate with an itemized copy of the denial and/or payment notification from the primary plan, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
9NE	We have not received all required information from the enrollee's employer to process this claim. The enrollee should check with their Group Benefit Department prior to submitting a new claim. The patient is responsible for the amount indicated as "Patient Pays".	N30 - Patient ineligible for this service.	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.	PR	PR	DENY	3
9NR	This policy does not provide reimbursement to the	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	DENY	3

	enrollee. Therefore, the patient is responsible for the amount indicated as "Patient Pays".	information about restrictions for this service.	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.				
9OP	Oral pathology procedures must be accompanied by a pathology report. Please submit a new claim or pre-treatment estimate with pathology report, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.	N402 - Incomplete/invalid periodontal charting.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PR	PR	DENY	1
9R2	The additional submitted documentation does not support payment of benefits for this procedure. Therefore, the original benefit determination remains unchanged. The patient is responsible for the amount indicated as "Patient Pays."	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
9RD	The additional submitted documentation does not support payment of benefits for this procedure. Therefore, the original benefit determination remains unchanged. Contracting providers agree	N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	3

	to charge the patient only the amount indicated as "Patient Pays."						
9RV	Benefits could not be determined because of missing subscriber information. Upon receipt of a new claim with the following information: Subscriber(s) name or date of birth, relationship to patient or a copy of a court order, if applicable. We will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	PI	PI	DENY	1
9UM	Benefit is limited. This service is not covered for Medicaid members.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
9WA	According to our guidelines, the fee for this procedure is considered to be part of, and included in the fee for a completed service. Please refer to Section Four of the	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment	PR	PI	DENY	4

	Dentist Handbook for dental policy and guidelines for this service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	Separate payment is not allowed.	(loop 2110 Service Payment Information REF), if present.				
9WB	Benefits could not be determined because the effective date of the primary coverage is missing. Please submit a new claim or pre-treatment estimate providing the information requested and a complete itemized copy of the denial and/or payment notification from the primary plan, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	22 - This care may be covered by another payer per coordination of benefits.	PI	PI	DENY	3
9WP	The original payment has been voided. The claim has been reprocessed and a new payment has been issued.	N32 - Claim must be submitted by the provider who rendered the service.	N/A	PI	PI	DENY	N/A
9Y7	Benefits could not be determined because this service requires the other carrier paid and allowed amounts. Please submit a	N4 - Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be	PR	PR	N/A	1

	new claim or pre-treatment estimate with the other carrier required information, other carrier paid, allowed and patient responsibility, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).				
AU9	Our records indicate the required referral/precertification is not on file. Therefore we cannot continue processing this claim or pre-determination.	N630 - Referral not authorized by attending physician.	183 - The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	3
B54	The contractual maximum for this service has been reached. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
BD7	Benefits could not be determined because this service requires radiographic images. Please submit a new claim or pre-treatment estimate with dated, diagnostic radiographic images, upon	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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	PI	PI	N/A	2

	receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
CP1	The deadline for submitting this procedure/claim has expired.	N202 - Alert: Additional information/explanation will be sent separately.	29 - The time limit for filing has expired.	PI	PI	N/A	3
CP3	The deadline for submitting this procedure/claim has expired.	N202 - Alert: Additional information/explanation will be sent separately.	29 - The time limit for filing has expired.	PI	PI	DENY	3
D01	The deadline for submitting this procedure/claim has expired.	N30 - Patient ineligible for this service.	29 - The time limit for filing has expired.	PI	PI	N/A	3
D34	Procedure code is not in the approved CDT code set for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in	N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.	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.	PI	PI	DENY	3

	processing, please do not attach a copy of this EOB to the new claim.						
D35	Benefits could not be determined because the submitted procedure number is not recognized. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.	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.	PI	PI	N/A	3
D56	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PI	PI	DENY	2

	submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Service Payment Information REF), if present.				
D57	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
D58	Benefits could not be determined because of missing/conflicting information. Please submit a	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At	PI	PI	DENY	2

	new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
D59	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	do not attach a copy of this EOB to the new claim.						
D60	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
D61	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
D62	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
D63	Benefits could not be determined because the procedure code submitted has incorrect or missing information about the tooth. Please submit a new	N37 - Missing/incomplete/invalid tooth number/letter.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP	PI	PI	DENY	2

	claim or pre-treatment estimate with the correct arch, quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines.		Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
D65	Benefits could not be determined because this service requires radiographic images. Please submit a new claim or pre-treatment estimate with dated, diagnostic radiographic images, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	N/A	2
D67	Benefits could not be determined because of missing/conflicting information. Please submit a new claim or pre-treatment estimate with arch,	N75 - Missing/incomplete/invalid tooth surface information.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP	PI	PI	DENY	2

	quadrant, tooth number, and/or surface code information, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
DD1	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

DD2	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
DD3	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2

	the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.						
DD4	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
DDB	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110	PI	PI	DENY	2

	processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Service Payment Information REF), if present.				
DDC	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
DDD	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	PI	PI	DENY	2

	fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.		Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
DDE	The ICD-10 code is invalid for the date of service. Please submit a new claim or pre-treatment estimate with correct and complete itemized procedure information including the fee and valid ICD code, upon receipt we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	M76 - Missing/incomplete/invalid diagnosis or condition.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
F65	Services outside the program's service area are not a benefit. The patient is	N130 - Consult plan benefit documents/guidelines for	242 - Services not provided by network/primary care providers.	PR	PR	DENY	3

	responsible for the amount indicated as "Patient Pays".	information about restrictions for this service.					
FDM	Orthodontic installment payments are issued automatically subject to the patient's continued eligibility. You do not have to do anything. The payments are already scheduled to be issued. Do not re-submit this notice.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
FDP	This procedure was previously processed or is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	N/A	3
FED	This procedure was previously processed or is a duplicate of another procedure on this claim.	N522 - Duplicate of a claim processed, or to be processed, as a crossover claim.	18 - Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	PI	PI	DENY	2
FLK	According to our guidelines, this service is not allowable. The patient is responsible for the amount indicated as "Patient Pays".	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	204 - This service/equipment/drug is not covered under the patient's current benefit plan	PR	PR	DENY	3
FLL	According to our guidelines, the fee for this procedure is considered to be part of, and included in the fee for a completed service. Contracting providers agree to charge the patient only	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	204 - This service/equipment/drug is not covered under the patient's current benefit plan	PI	PI	DENY	3

	the amount indicated as "Patient Pays."						
FLN	This procedure was previously processed or is a duplicate of another procedure on this claim.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
FLW	Our records indicate history of this service was previously paid to the provider within the plan frequency. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PI	DENY	3
FLX	Our records indicate history of this service was previously paid to the provider within the plan frequency. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PI	DENY	3
FLY	We have applied an alternate benefit. Our records indicate a restoration was placed on one or more surfaces by this provider within the plan frequency. Benefits are allowed only once per surface. Contracting	M86 - Service denied because payment already made for same/similar procedure within set time frame.	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.	PR	PI	DENY	3

	providers agree to charge the patient only the amount indicated as "Patient Pays."						
FM0	An adjustment has been made for the maximum allowable radiographic images/photos.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	P14 - The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	PR	PR	DENY	4
FM1	The maximum allowance for radiographic images is applied.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PR	DENY	3
FM5	The contractual maximum for this service has been reached. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PI	PI	DENY	3
FMD	Exclusion applies as listed in Evidence of Coverage: A duplicate claim was received. There is a history of the same procedure being provided for this enrollee on the same date of service.	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	PI	PI	DENY	3
FMF	According to our guidelines, the fee for this procedure is considered to be part of,	N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.	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	PI	PI	DENY	3

	and included in the fee for a completed service.		Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
FMG	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with a current periodontal chart, dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
FMH	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with a current periodontal chart, dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
FMI	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP	PI	PI	DENY	2

	estimate with dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.		Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
FMJ	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
FMK	This claim or pre-treatment estimate has been selected for Professional Review and will require additional information. Please submit a new claim or pre-treatment estimate with dated, pre-operative diagnostic radiographs and a copy of the patient treatment record.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
FML	This claim or pre-treatment estimate has been selected for Professional Review and will require additional	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At	PI	PI	DENY	2

	information. Please submit a new claim or pre-treatment estimate with a current periodontal chart, dated, pre-operative diagnostic radiographs, and a copy of the patient treatment record.		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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
FMS	The fee for a sealant completed on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the fee for the restoration.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
FMT	The fee for a sealant includes repair or replacement within 24 months by the same dentist/dental office.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
FMU	A sealant is not a separately payable service if provided on a tooth surface with a restoration.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
FMV	Radiographic images and clinical chart notes indicating necessity of treatment are required	N716 - Missing chart.	163 - Attachment/other documentation referenced on the claim was not received.	PR	PI	DENY	1

	when submitting a claim or pre-treatment estimate for surgical removal of impacted teeth.						
FMW	Pre and post-operative periapical images are required when submitting a claim for endodontic therapy and select endodontic procedures. A pre-treatment estimate for these procedures requires pre-operative periapical images.	N178 - Missing pre-operative images/visual field results.	250 - The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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).	PR	PI	DENY	1
FNA	The fees for a re-evaluation/post –operative office visit to be part of, and included in the fee for a completed service. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	DENY	4
FNB	The submitted procedure is not payable due to the absence or conflict of a related service that is in our records for this patient. Contracting providers agree to charge the patient only the amount indicated as "Patient Pays."	M80 - Not covered when performed during the same session/date as a previously processed service for the patient.	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.	PR	PI	DENY	3
FNC	According to our guidelines, allowance has been	M86 - Service denied because payment already	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PI	DENY	3

	previously provided for a sealant or preventive resin restoration procedure. The patient is responsible for the amount indicated as "Patient Pays."	made for same/similar procedure within set time frame.	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.				
FND	According to our guidelines, allowance has been previously provided for a restorative procedure. The patient is responsible for the amount indicated as "Patient Pays."	M86 - Service denied because payment already made for same/similar procedure within set time frame.	119 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	DENY	3
FNH	Radiographic images are required when submitting a claim or pre-treatment estimate for surgical extractions on primary teeth, and for removal of impacted teeth, completely bony.	N178 - Missing pre-operative images/visual field results.	163 - Attachment/other documentation referenced on the claim was not received.	PR	PI	DENY	1
FNI	According to our guidelines, the fee for image capture is considered to be included in the fee for the images/radiographs. A separate fee is not billable to the patient.	N40 - Missing radiology film(s)/image(s).	250 - The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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).	PI	PI	DENY	1
FNL	Radiographic images are required when scaling and root planing is submitted on patients under 30 years of	N178 - Missing pre-operative images/visual field results.	163 - Attachment/other documentation referenced on the claim was not received.	PR	PI	DENY	1

	age. Related services (such as D1110, D1120, D4346, D4355, and/or D4910) submitted on the same claim will be reviewed upon submission of a new claim or pre-treatment estimate with the required radiographs.						
FNO	This procedure was previously processed; or appears to be a duplicate of a procedure that has been recently denied because the member had exceeded their annual maximum. If you wish to request a reevaluation of this action, use the Provider Inquiry Form available online or submit a new claim with additional supporting documentation (i.e., copies of x-rays, photos and/or clinical comments) to: Delta Dental; Provider Dispute; PO Box 997330; Sacramento, CA 95899-7330.	N435 - Exceeds number/frequency approved /allowed within time period without support documentation.	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.	PR	PI	DENY	3
FNS	This procedure was previously processed. If you have additional information pertaining to this procedure, please submit it using the Provider Inquiry Form	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP	PI	PI	DENY	2

	available at deltadentalins.com for reconsideration.		Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.				
FNX	This procedure was previously processed. Additional information pertaining to this procedure must be submitted using the Provider Inquiry Form available at deltadentalins.com for reconsideration.	M129 - Missing/incomplete/invalid indicator of x-ray availability for review.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PI	PI	DENY	2
FNY	Services performed outside the provider Network are not a benefit. However, emergency services may be available. Please refer to your plan benefit for coverage detail. You may contact the Delta Dental customer service department to discuss emergency service coverage. The patient is responsible for the amount indicated as "Patient Pays".	M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	242 - Services not provided by network/primary care providers.	PR	PR	DENY	3
FNZ	Exclusion applies as listed in Evidence of Coverage: There	N130 - Consult plan benefit documents/guidelines for	96 - Non-covered charge(s). At least one Remark Code must be provided (may be	PR	PR	PDMD	3

	is no coverage for dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized Dental Specialist, or a Contract Orthodontist except for emergency services as described in the Contract and/or Evidence of Coverage.	information about restrictions for this service.	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.				
ME2	The patient was not eligible when this service was performed or submitted for predetermination. You may use our online provider Tools for eligibility and benefits information, including remaining maximums and deductibles.	N30 - Patient ineligible for this service.	26 - Expenses incurred prior to coverage.	PR	PR	DENY	3
ME3	The patient was not eligible when this service was performed or submitted for predetermination.	N30 - Patient ineligible for this service.	27 - Expenses incurred after coverage terminated.	PR	PR	DENY	3
ME4	The patient was not eligible when this service was performed or submitted for predetermination.	N20 - Service not payable with other service rendered on the same date.	27 - Expenses incurred after coverage terminated.	PR	PR	DENY	3
ME5	The patient was not eligible when this service was performed or submitted for predetermination.	N30 - Patient ineligible for this service.	27 - Expenses incurred after coverage terminated.	PR	PR	DENY	3
ME6	The patient was not eligible when this service was	N30 - Patient ineligible for this service.	27 - Expenses incurred after coverage terminated.	PR	PR	DENY	3

	performed or submitted for predetermination.						
ME7	The patient's eligibility ended before this service was provided. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	27 - Expenses incurred after coverage terminated.	PR	PR	DENY	3
MFC	Claim is returned. We are no longer the third party administrator for this group.	N622 - Not covered based on the date of injury/accident.	27 - Expenses incurred after coverage terminated.	PR	PI	DENY	3
MFD	The deadline for submitting this procedure/claim has expired.	N622 - Not covered based on the date of injury/accident.	27 - Expenses incurred after coverage terminated.	PR	PI	DENY	3
MX3	The patient was not eligible when this service was performed or submitted for predetermination. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N30 - Patient ineligible for this service.	27 - Expenses incurred after coverage terminated.	PR	PR	DENY	3
PVU	The deadline for submitting this procedure/claim has expired.	N182 - This claim/service must be billed according to the schedule for this plan.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PR	DENY	2

PVW	The deadline for submitting this procedure/claim has expired.	N182 - This claim/service must be billed according to the schedule for this plan.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	N/A	2
PVZ	The deadline for submitting this procedure/claim has expired.	N182 - This claim/service must be billed according to the schedule for this plan.	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. 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.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	PR	PI	N/A	2
7MC	This service is not a covered benefit for the policy holder of the account, only for dependents. Therefore, the patient is responsible for the amount indicated as "Patient Pays."	N130-Consult plan benefit documents/guidelines for information about restrictions for this service	96-Non-covered charge(s)At least one Remark code must be provided	PR	PI	DENY	1

1DM	Benefits for more units of general anesthesia or IV sedation than the patient's plan permits will require written documentation explaining the rationale for the extended anesthesia time. Necessary documentation, for completed treatment, includes all associated X-rays, progress notes and the complete anesthesia record and, for pre-treatment estimates, x-rays, and a narrative. Please submit a new claim or pre-treatment estimate, with the necessary documentation. Upon receipt, we will process the submitted service(s) in accordance with our processing guidelines. To prevent delays in processing, please do not attach a copy of this EOB to the new claim.	119 - Denied services exceed the coverage limit for the demonstration.	M139 - Benefit maximum for this time period or occurrence has been reached.	PR	PI	Deny	1
12R	Post & Core and related restorative/fixed prosthetics are payable only on an endodontically treated tooth. Benefits could not be determined because the submitted radiograph(s) does not depict completed root canal therapy. If root canal treatment has been completed, submit a post operative periapical image and narrative.	251 - Incomplete/Invalid post-operative images/visual field results.	N679 - Incomplete/Invalid post-operative images/visual field results.	PR	PI	Deny	1