Claim Explanation Codes

If the claim was denied in full, submit the claim again as a new claim to WPS. If the claim was partially paid or denied, please use the Corrected Claim Form.

Denial Code	Description
105, ABF, ABG, AHZ	Primary carrier's Explanation of Benefits is required.
349, AAZ, AIA, W39	Medicare Explanation of Benefits is required.
AAA	Resubmit claim to Medicare with the information requested. When Medicare has determined benefits, send the Medicare EOB to us for processing.
AAB	Medicare assignment was accepted and the provider has agreed to reduce the charge by this amount. No patient responsibility.
AAM, AHO, CDD	This claim is a duplicate of a previously submitted claim.
AAV, AAW	The EOB received from the primary carrier does not reflect the original paid/denied charges. Please submit the original explanation.
ABY, AIH	The charges are not covered because they were billed in error by the provider of service.
ACZ	Claim processed per coordination of benefits with the patient's primary plan coverage. This may result in a reduction of payment.
AEF	Family Care COB calculation method.
AHP	This service line is a duplicate of a previously submitted claim.
AIF, ANM, TF0	This claim was submitted after the claim filing limit.
AJN, XDX	The diagnosis code(s) entered is invalid for the date(s) of service billed on the claim.
AJO, K01, S10, S11, S12, S13, S14, S1C, S20, S21, S22, S23, W01	The patient's coverage was not in effect on the date the services were provided.
AMQ, AMS	Primary carrier has requested additional information. When primary has determined benefits, resubmit claim and EOB for processing.
AMR, AMT	Claim was not submitted to primary in a timely manner. When primary has overturned its decision, resubmit claim and EOB for processing.
AMX	This service or supply was submitted without an authorization number. Please resubmit with the Family Care MCO authorization number.
ANF	Payment based on contracted rate or Medicaid fee schedule.
FAB	There is no authorization on file for this participant for the dates of service, procedure code, modifier, or provider billed on the claim.
FAC	Extra mileage service is not reimbursable without the base transportation code billed on the same claim with the same date of service.
FAD	The authorization number submitted is invalid for the service or supply billed.
FAE	The authorized number of units or amount for this service has been exceeded.
FAF	The service or supply submitted does not match the authorization. Resubmit with the correct service code.
FAH	The required NPI number is missing from the claim.
FAI	The provider of service was not authorized to provide this service.
FAJ	The NPI number submitted was not valid.
FAK	The date of service is either before or after the date range authorized.
FAL	Date of service for extra mileage code must be the exact same date of service as the base transportation code.
FAM	The member number submitted on the claim does not match the member number on the authorization referenced.
NON	Provider is not in the MCO/CWA network.
p03	A diagnosis is missing, missing digits or indicators, or is invalid for the procedure, date, order, or when billed with other diagnoses.
R45	Reimbursement for this service is made according to the provider contracted rate.
WG0	The type of bill submitted is invalid for the date of service on the claim.
WG3	Personal care and home health services must be billed on an Institutional claim with a valid revenue code and authorized CPT/HCPCS code.
WGM	The place of service submitted is invalid for the date of service on the claim.
XK5	Services and supplies for the purpose of education, self-fulfillment, or vocational training are not covered.
XPC	The procedure code(s) entered is invalid for the date(s) of service billed on the claim.
z12	This claim line is disallowed because the procedure code is missing or invalid.

WPS HEALTH INSURANCE

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