

ASC X12N 837 v.5010 Error Codes and Messages

Page updated: July 2025

Prior to entry in the daily claims edit cycle, ASC X12N 837 v.5010 submissions must pass numerous system edits. Claims failing these edit requirements will be rejected and returned to the provider for correction. The error codes and messages listed on the following pages will appear in the *Volser Summary report* on the Medi-Cal Provider Portal.

837 Claim Error Codes and Messages Table

Codes	Messages	«Suggested Resolution
001	CMC Replacement/Void claim cannot be billed with multiple claim lines	Only one line at a time can be replaced. Only Medi-Cal has this restriction. Refer to <i>Electronic Methods for Eligibility Transactions and Claims Submission</i> section in Part 1 of the Provider Manual.
002	Invalid Submission Date in Submitter Control Record	No specific loop or segment
003	Invalid Submitter Name in Submitter Control Record	Loop 1000A NM103-NM105
004	Invalid Claim Count in Submitter Control Record	No specific loop or segment
005	Invalid Billing Amount in Submitter Control Record	No specific loop or segment
006	Invalid Provider Count in Submitter Control Record	No specific loop or segment
007	Invalid create date in Submitter Control Record	Common header BHT04 (Can't find future date)
008	Submitter not on submission agreement file *	Loop 100A NM109 (no app on file)
009	Provider control record missing or invalid	No specific loop or segment
010	Data was previously accepted for processing	Same provider count, claim count and dollar amount as previous file. (Passing test error)
011	Amount billed on Provider Control Record does not balance	No specific loop or segment
012	Claim count on Provider Control Record does not balance	No specific loop or segment
013	Submitter ID on Provider Control Record is invalid	Loop 1000A NM109»

837 Claim Error Codes and Messages Table (continued)

Codes	Messages	«Suggested Resolution
014	Provider ID on Provider Control Record is invalid	Loop 2010AA NM109
016	Submission Date on Provider Control Record is not a valid date	Group start GS04 (can't be future date)
017	Provider Name on Provider Control Record is invalid	Loop 2010AA NM103
018	Provider Address line 1 on Provider Control Record is invalid	Loop 2010AA N301
019	Telecommunication Certification Statement missing or invalid	Not in new ANSI
020	Provider City on Provider Control Record is invalid	Loop 2010AA N401
021	Provider State on Provider Control Record is invalid	Loop 2010AA N402
022	Provider ZIP in Provider Control Record is invalid	Loop 2010AA N403
023	Provider Phone on Provider Control Record is invalid	Loop 2010AA PER04
024	Claim Count on Provider Control Record is invalid	No specific loop or segment
025	Billing Amount on Provider Control Record is invalid	No specific loop or segment
027	Provider/claim type not on active status †	Not approved by DHCS yet»

837 Claim Error Codes and Messages Table (continued)

Codes	Messages	«Suggested Resolution
028	Submission Date on Claim Record not a valid date	No specific loop or segment
029	Not applicable to submitter	xxx Records bypassed until next valid record found (from error 33)
030	Claim is not valid for current Provider Control Record	No specific loop or segment
031	Amount Billed on Submitter Control Record does not balance	No specific loop or segment
032	Claim Count on Submitter Control Record does not balance	No specific loop or segment
033	Job terminated - maximum number of errors exceeded *	No specific loop or segment
034	Amount field of a claim was not numeric	Loop 2300 CLM02 or too many lines like error 38 or just not numbers* see below
035	Provider Count on Submitter Control Record does not balance	No specific loop or segment
036	Claim contains an embedded blank line	No specific loop or segment
037	Line numbers not in ascending sequence	Loop 2400 LX-LX01
038	Line numbers outside valid range of claim type	Loop 2400 LX or too many lines (Medical equals 50 lines, Inpatient or Outpatient equals 999 lines, LTC equals one line, Vision equals none and Crossover equals 15)
039	Receipt record was not matched to Submitter Control Record *	No specific loop or segment
040	Unable to identify Submitter Control Record - record type not spaces	record-type not spaces – Loop 1000A
041	Receipt file check bypassed due to prior error *	No specific loop or segment
042	Submitter agreement check bypassed due to prior error *	No specific loop or segment
043	CMC Replacement for previously processed CIF/Appeal is not Allowed	Loop 1000A»

837 Claim Error Codes and Messages Table (continued)

Codes	Messages	«Suggested Resolution
044	Duplicate control record for same provider/claim type	Loop 2010AA NM1-NM109 same billing provider NPI used over and over
045	Submission Date on Submitter Control Record exceeds process date	Group start GS04 or future billing
046	Submission Date on Provider Control Record exceeds process date	Interchange start ISA09 or future billing
047	Submission Date on Claim Record exceeds process date	Group start GS04 or future billing (sent before date of service)
048	Claim Sequence Number not numeric	Loop 2400 LX-LX01 or more than one GS segment pre submission (two files, one submission etc.)
049	Attachment count on Submitter Control Record not numeric or blanks	No specific loop or segment
050	Attachment count on Provider Control Record does not balance	No specific loop or segment
051	Attachment count on Provider Control Record is invalid	No specific loop or segment
052	Attachment count on Submitter Control Record does not balance	No specific loop or segment
053	Record sequence number not a claim or attachment	No specific loop or segment
054	Claim sequence number not unique for provider/claim type	No specific loop or segment/Duplicate Claim Sequence Number
055	Submitter/claim type not approved for included attachment	Loop 2300 NTE02 not approved by DHCS yet
056	Attachment Record does not pair up with prior Claim Record	No specific loop or segment
057	Record sequence numbers on attachments not consecutive	No specific loop or segment
058	Media type/claim type not valid for this submitter	No specific loop or segment Loop 2010BB NM103
059	Submitter Control Record duplicate is invalid	Common Header Loop 1000A or more than one GS»

837 Claim Error Codes and Messages Table (continued)

Codes	Messages	«Suggested Resolution
062	Provider not valid for claim type billed	2010AA NM109
063	No claim records present	Loop 2300 CLM-CLM20
064	Claim type is inconsistent with record length	No specific loop or segment
065	Invalid record length	No specific loop or segment
067	Gross amount field on claim record is not numeric	Loop 2300 CLM02 (see error 34, 38)
069	Total charge field on claim record is not numeric	Loop 2300 CLM02 (see error 34, 38)
070	Amount field on claim record is not numeric	Loop 2300CLM02 (see error 34, 38)
071	Provider on remarks different from claim provider	No specific loop or segment
073	Field level error-please refer to test letter	No specific loop or segment
074	Point of pickup ZIP code must be numeric and contain 5 or 9 digits	No specific loop or segment
075	Point of drop-off ZIP code must be numeric and contain 5 or 9 digits	No specific loop or segment
076	Claim has both OHC and Medicare Payments and must be hardcopy billed	No specific loop or segment
077	Payer Claim Control Number is not 13 Digits	Refer submitter to the <i>Electronic Methods for Eligibility Transactions and Claims Submission</i> section in Part 1 of the Provider Manual.
078	Invalid bill type for CMC crossover claims	Loop 2300 CLM05 (some places of service can't do CMC crossovers for legal reasons) (FQHC just bill a crossover code)
079	Medicare type is invalid	Crossover or TLP
080	Submitter not approved to bill crossover claims for this media type	Loop 2320 or 2430. Needs to pass crossover test claims first»

837 Claim Error Codes and Messages Table (continued)

Codes	Messages	«Suggested Resolution
081	Missing Medicare Claim Adjudication Date	Loop 2330B DTP
082	Charpentier claims must be billed on paper	No specific loop or segment
083	RHC/FQHC/IHS/MOA crossover claims must be billed on paper	Use a crossover HCPCS code with an attachment or note
084	Medicare Payer ID not present	Loop 2330B REF
085	Benefits assignment indicator is not "Y"	Loop 2300 CLM08 or Loop 2320 OI03
086	Claim Line Coinsurance > Medicare Paid	Loop 2320 CAS segment ----- sometimes confusing deductible with coinsurance
087	Medicare 100% Paid (COINS=0, DEDUCT=0, BLOOD DED=0, PAID>0)	Loop 2320 CAS segment ----- sometimes confusing deductible OR coinsurance with another payment responsibility
088	Medicare Denial (COINS=0, DEDUCT=0, BLOOD DED=0, PAID=0)	Loop 2320 CAS segment. Medicare denials are billed as straight Medi-Cal with the denial EOB as an attachment
089	Claim Line Coinsurance > 0 and Medicare Paid = 0	Loop 2320 CAS segment ----- sometimes confusing deductible with coinsurance
090	Service ZIP Code on Provider Control Record is not numeric	Needs to be all 9»

837 Claim Error Codes and Messages Table (continued)

Codes	Messages	«Suggested Resolution
091	Billing Provider Address is invalid. PO Box or Lock Box is not acceptable	PO Box or Lock Box is not acceptable
092	Billing Provider ZIP Code Format = Numeric, Length of 9	PO Box or Lock Box is not acceptable
093	Service Facility address is invalid. PO Box or Lock Box is not acceptable	Refer submitter to the <i>Electronic Methods for Eligibility Transactions and Claims Submission</i> section in Part 1 of the Provider Manual.
094	Service Facility ZIP code Format = Numeric, Length of 9	Numeric, Length of 9
095	Ambulance Pick Up address is invalid. PO Box or Lock Box is not acceptable	Numeric, Length of 9
096	A claim cannot contain both ICD-9 and ICD-10 qualifiers	No specific loop or segment
097	ICD-9 codes not valid for dates on/after ICD-10 compliance date	Mostly wrong dates (1921 etc.) or no dates <00000000> (each line needs a date on multi-day claims)
098	ICD-10 codes not valid for dates prior to ICD-10 compliance date	Mostly wrong dates (1921 etc.) or no dates <00000000> (each line needs a date on multi day claims)>>

«837 Professional Claim Error Codes and Messages Table»

Codes	Messages	«Suggested Resolution
015	Claim type on Provider Control Record is invalid	Loop 2010BB NM103 equals Medi-Cal MED, NM109 equals 610442
026	Provider/claim type not valid for this submitter -OR ZIP code of the service address or the tax ID or the owner number doesn't match records.	Loop 2010AA NM109 relation to Loop 2010BB NM103 Note: Only the claim types that match the DHCS provider type are allowed. Hospitals cannot use 05 or 06 etc.
060	Provider Control Record contains invalid record type	Loop 2010AA NM1-NM109
061	Claim type on claim record is invalid	Loop 2010BB NM103
066	Line charge field on claim record is not numeric	Loop 2400 SV102 (see error 34, 38)
068	Service charge field on claim record is not numeric	Loop 2300 SV102 (see error 34, 38)»»

«837 Institutional Claim Error Codes and Messages Table»

Codes	Messages	Suggested Resolution
015	Claim type on Provider Control Record is invalid	Loop 2010BB 5010, NM103 (NM103 equals Medi-Cal OP, Medi-Cal IP, Medi-Cal LTC and NM109 equals 610442)
026	Provider/claim type not valid for this submitter † -OR ZIP code of the service address or the tax ID or the owner number doesn't match records.	Loop 2010AA NM109 relation to Loop 2010BB NM103. NM103 must be Medi-Cal LTC or Medi-Cal IP or it will be processed as default OP. Note: Only claim types that match the DHCS provider type are allowed. Pharmacies cannot use 02 or 03 etc.
060	Provider Control Record contains invalid record type	Loop 2010AA NM1-NM109
061	Claim type on claim record is invalid	Loop 2010BB NM103
066	Line charge field on claim record is not numeric	Loop 2400 SV102 LTC SV201 (see error 34, 38)
068	Service charge field on claim record is not numeric	Loop 2300 SV102, LTC SV201 (see error 34, 38)

837 Claim Submission Translation Errors

837 claim submission ITX translation errors are listed in the *Error report* that is available in the EDI Submission application within the Medi-Cal Provider Portal. Providers with questions about report details can call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday, except holidays.

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Not programmable by submitter
†	Verify with the approval letter from DHCS