

Common Denials

The following is a list of our most common denials and tips on how to make corrections to the denials when applicable.

Explain Code	EOB Description	Website Additions
41	Not a Program Benefit	This is a service that is excluded under the plan or the code used is incorrect or unbundled for a covered service.
42	Denied Per Medical Review	Claims reviewed by CenCal Health's Medical department that are denied, can be disputed. Supporting documentation must be attached for reconsideration.
44	Provider and/or Provider Number Not Eligible for Program on Date of Service	Provider NPI numbers must be valid and updated through the state in order to be uploaded in CenCal's processing system. Claims without a valid NPI will be denied.
5B	Procedure/Service Requires Correct & Appropriate Diagnosis	A diagnosis which justifies this service was not billed. Please resubmit with additional diagnosis(es) or an explanation of medical necessity.
92	Provider Signature Missing	Paper claim forms submitted to CenCal Health require the signature of the Provider or Provider Representative in order to be considered for payment.
AD	Provider Billing NPI Invalid on Date of Service Billed	Provider NPI numbers must be valid and updated through the state in order to be uploaded in CenCal's processing system. Claims without a valid NPI will be denied.
DA	Service/Supply is not a Benefit	The following procedure codes are not a benefit of CenCal Health, and if billed, will be denied:
FX	The Rendering Provider/NPI is Unknown; Please Contact CenCal Health's Provider Services Dept.	Rendering Provider numbers must be valid and updated through the state in order to be uploaded in CenCal's system. Medical Groups are required to keep CenCal Health's Provider Service Dept. updated with all additions/deletions of Rendering Providers within their Group. Rendering Providers not updated with CenCal Health will be denied.
9F	Provider # on Claim Does not Match Provider # on Authorization	Provider numbers (NPI's) billed on claims where authorizations (TAR's etc.) are required, must match. Provider numbers on claims not matching the Provider numbers on authorizations will be denied.
TA	Service Limit Exceeded; Denial May Be Reconsidered with Documentation	Procedure codes with billing restrictions (1 time per day, once every six months etc.) can be considered with appropriate documentation to support the additional services. Approved authorizations will suffice as documentation.
UA	Incorrect Provider Type for Claim	Taxonomy codes are required for multi-specialty Provider groups. Claims billed without a appropriate taxonomy code will be denied.