TOP 20 CLAIMS REJECTION CODES AND EXPLANATIONS

REASON CODE	REMARKS DESCRIPTION	EXPLANATION OF REMARK CODE
B6+A2:A21	Maximum annual benefits exceeded	The limit/amount allocated for this benefit category e.g. PMSA (Personal Medical Savings Account) or PCB (Primary Care Benefit) has been used up.
B7	Paid at agreed tariff	OMSMAF pays claims at 100% of MSR (Medical Scheme Rate), refer to the tariff amount column. Members will be liable to those Providers who charge more than 100% of MSR (Medical Scheme Rate).
RP	Accumulated Savings Sweep	A portion of this claim has been paid from your Accumulated Savings.
D3	Amount above MMAP	MMAP (Maximum Medical Aid Price) The amount charged is more than the benchmark or reference price for generically similar products i.e. there are alternative generic medicines available at a lower cost, please ask your Pharmacist for other generic alternatives to avoid the co-payment.
G4	Duplicate submission	This same claim has previously been processed.
MK	Medication rejected - refer Medikredit script	Medication short paid due to co-payment applied for out of formulary medicines.
A2	Treatment related to an exclusion	This treatment is regarded as excluded from benefits in terms of the Funds rules.
AA	Amount above agreed tariff - Member not Liable	Negotiated rates are in place for this service and the provider should not be charging above this agreed rate (refer to tariff amount column for this agreed rate). Member is not liable for this rejected amount.
B3	Service after termination of membership	Member/dependants can only claim whilst membership is active. This treatment was rendered after the member's/dependant's termination date and is the members liability.
A8	Non-chargeable items	Negotiated charges are in place for this service and the provider/facility should not be billing for it. These charges should be credited by the provider/facility.
SD	Supply proof of Authorisation for date of treatment	Service not paid due to no authorisation obtained prior to the procedure/operation or authorisation was declined.
G1	Doctor letter required	We require a motivation letter from the treating provider in order to review this treatment.
PL	PMB Protocol max qty exceeded	As per the PMB (Prescribed Minimum Benefits) level of care guidelines and protocols in place, there is a maximum quantity of medicines/treatment allowed and this quantity is used up.
I1	Amount above Network contract	For the Network and Network Select Plan, there are agreed rates in place with the contracted Network providers. The provider should not charge above this agreed rate.
B2	Claim not submitted within time period	The claiming period for all claims is 4 months from the treatment date. Our records indicate that this claim was not submitted/processed within this 4 month stale claim period and requires proof of prior submission.
A9	Tariff codes required	A tariff code must be submitted with every claim line as this is a description of the type of service that was rendered. Kindly request a detailed account from the provider which includes the relevant tariff codes.
P8	Specialist Pre Auth Req Phone 0860111090	For the Network and Network Select Plans, a Specialist authorisation is required for all Specialist referrals/ visits. This rejection occurs when a Specialist consultation/visit has not been authorised and the same Specialist has referred you for Radiology (x-rays) or Pathology (blood tests) or has prescribed medication.
CP	Co-payment Apply	In terms of the Funds rules, this treatment has a co-payment applied to it for which the member is liable to pay the provider directly.
MS	Member/Company suspended	Membership has been suspended, kindly contact our finance department on 0860 100 076.
DD	Invalid date of birth	The member's/dependant's date of birth on the account received does not correspond with the date of birth reflected on the member's membership profile.

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