Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
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	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
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EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
A1	This claim was refused as the billing service provider submitted is: a) not found in our Practitioner Registry database or b) the billing provider field was blank.	Please make appropriate change and resubmit new claim.	R
A2	This claim was refused as date of birth cannot be after service date of claim. Please check your records to confirm the date of birth.	Please make appropriate change and resubmit new claim.	R
A3	This claim was refused as date of service cannot be after receipt date of claim. Please check your records to confirm the date of service.	Please make appropriate change and resubmit new claim.	R
A4	This claim was refused as given name of reciprocal patient is mandatory for non-resident claim.	Please make appropriate change and resubmit new claim.	R
A5	This claim was refused as surname of reciprocal patient is mandatory for non-resident claim.	Please make appropriate change and resubmit new claim.	R
A6	This claim was refused as a full date of birth of reciprocal patient is mandatory for non-resident claim.	Please make appropriate change and resubmit new claim.	R
A7	This service was refused as the eligibility criteria for publicly funded vaccines was not met.	No further action required.	I
A8	This service has been assessed at the minimum benefit amount for procedures performed with general anesthesia.	No further action required.	I
A9	This claim was refused as gender of reciprocal patient is mandatory for non-resident claim.	Please make appropriate change and resubmit new claim.	R
A0	Given name of patient submitted on claim was corrected to match our records. Update your records accordingly and use the correct given name when submitting future claims.	Please update your records accordingly.	I
B1	Surname of patient submitted on claim was corrected to match our records. Update your records accordingly and use the correct surname when submitting future claims.	Please update your records accordingly.	I
B2	Birth year of patient submitted on claim was corrected to match our records. Update your records accordingly and use the correct birth year when submitting future claims.	Please update your records accordingly.	I
B3	Gender of patient submitted on claim was corrected to match our records. Update your records accordingly and use the correct gender when submitting future claims.	Please update your records accordingly.	I
B4	Family registration number of patient submitted on claim was corrected to match our records. Update your records accordingly and use the correct family registration number given when submitting future claims.	Please update your records accordingly.	I

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B5	PHIN of patient submitted on claim was corrected to match our records. Update your records accordingly and use the correct PHIN when submitting future claims.	Please update your records accordingly.	I
B6	This service was refused as routine prenatal care should not be claimed for a hospital in-patient or if rendered in the emergency or outpatient department. Please submit a new claim with an ICD9 appropriate to the patient's complication.	Please make appropriate change and resubmit new claim.	R
B7	This claim was refused as the date of service cannot be blank.	Please make appropriate change and resubmit new claim.	R
B8	This claim was refused as the date of service is invalid.	Please make appropriate change and resubmit new claim.	R
B9	This claim was refused as the province for this reciprocal patient is: a) blank or b) invalid. Note: Quebec does not participate in the inter-provincial reciprocal billing agreement.	Please make appropriate change and resubmit new claim.	R
B0	This claim was refused as the benefit catalogue item cannot be blank.	Please make appropriate change and resubmit new claim.	R
C1	This claim was refused as this benefit catalogue item must be submitted with supportive information as outlined in the Physician's Manual. This information is either missing or incomplete. Submission of new claim must include remarks.	Please make appropriate change and resubmit new claim.	R
C2	This claim was refused as this service was not submitted within 6 months from the date on which the service was rendered.	No further action required.	I
C3	This claim was refused as our records indicate that the billing service provider number submitted is not linked to this electronic user site on this service date.	Please make appropriate change and resubmit new claim.	R
C4	This claim was refused as this service requires the number of anesthesia units field to be populated.	Please make appropriate change and resubmit new claim.	R
C5	This claim was refused as services rendered by In-Hospital Radiology specialty types must be provided in a designated hospital facility.	If applicable, please make appropriate change and resubmit new claim.	R
C6	This claim was refused as services rendered by this service provider type must be provided in a hospital facility.	If applicable, please make appropriate change and resubmit new claim.	R
C7	This claim was refused as the treatment location of clinic, emergency or outpatient was entered on your claim with: a) blank facility or b) invalid type of facility.	Please make appropriate change and resubmit new claim.	R

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C8	This claim was refused as the hospital facility submitted is not effective on this date of service.	If applicable, please make appropriate change and resubmit new claim.	R
C9	This claim was refused as we have no record of a surgical service on this date for this patient. Please check your records and if required contact the surgeon for confirmation of claim details.	Please make appropriate change and resubmit new claim.	R
C0	This claim was refused as the billing service provider number is not effective on this date of service.	If applicable, please make appropriate change and resubmit new claim.	R
D1	This claim was refused as the gender of the patient does not coincide with the ICD9 submitted.	If applicable, please make appropriate change and resubmit new claim.	R
D2	This claim was refused as the benefit catalogue item or PHIN submitted is not correct for Pre-Operative Anesthesia Clinics (Preana Clinic).	Please make appropriate change and resubmit new claim.	R
D3	This claim was refused as the benefit catalogue item or PHIN submitted is not correct for In-Hospital On-Call Anesthesia Coverage (Jane on Call).	Please make appropriate change and resubmit new claim.	R
D4	This claim was refused as the gender of patient does not coincide with the benefit catalogue item submitted.	If applicable, please make appropriate change and resubmit new claim.	R
D5	This claim was refused as the age of the patient does not coincide with the benefit catalogue item submitted.	Please make appropriate change and resubmit new claim.	R
D6	This service was refused as a Pathologist is not acceptable as a referring provider for consultations. If the referring service provider number was incorrect submit a new claim with correction. If the referring service provider was correct and re-assessment is required submit a formal query with supportive information.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
D7	This service was refused as the referring service provider number submitted is a generic billing number and should not be used for consultations. Submit a new claim with referring service provider's personal billing number.	If applicable, please make appropriate change and resubmit new claim.	R
D8	This service was refused as the referring /interpreting provider cannot be the same as the service provider.	Please make appropriate change and resubmit new claim.	R
D9	This service was refused as a referring service provider is required when submitting claims under a generic billing number.	Please make appropriate change and resubmit new claim.	R
D0	This claim was refused as services submitted under teaching providers may only be claimed in a teaching hospital facility. The facility submitted on the claim does not belong to a teaching facility.	If appropriate, please make appropriate change and resubmit new claim.	R
E1	This claim was refused as services rendered to members of your family or yourself are an excluded service under *The Health Services Insurance Act.*	No further action required.	I
E2	This claim was refused as this patient voluntarily signed an agreement to restrict office visits to one primary service provider. Please check PURC listing.	No further action required.	I

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EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
E3	This claim was refused as this service provider has been restricted from seeing this patient under the PURC program.	No further action required.	I
E4	This claim was refused as a facility number is required when submitting claims under a generic billing number.	If appropriate, please make appropriate change and resubmit new claim.	R
E5	This service was refused as the referring service provider billing number submitted for Midwifery Assessment & Report is not acceptable.	Please make appropriate change and resubmit new claim.	R
E6	This service was refused as a Dentist or Oral Surgeon is not acceptable as the referring service provider for this service.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
E7	This service was refused as an Optometrist is not acceptable as a referring service provider as there is no reference on the visit page for this benefit catalogue item.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
E8	This service was refused as it should not be claimed under a generic billing number. Submit a new claim under the service provider's personal billing number.	Please make appropriate change and resubmit new claim.	R
E9	This service was rejected as our records indicate that this service provider is restricted from performing this service.	No further action required.	I
E0	This service was rejected as fee-for-service claims are not claimable at this facility.	No further action required.	I
F1	This service was refused as the patient's coverage is not effective on the service date submitted.	If service date entered on original claim was incorrect please make appropriate changes and resubmit new claim.	R
F2	This service was refused as our records indicate that the patient's date of death is prior to the date of service. Please check your records to confirm the date of service.	If service date entered on original claim was incorrect please make appropriate changes and resubmit new claim.	R
F3	This service was refused as we are unable to identify this patient as a Manitoba resident.	No further action required.	I
F4	This service was refused as our records indicate that this patient is identified as a resident of another province or country.	No further action required.	I
F5	This service was rejected as this patient is not eligible under the Plan. Our records indicate patient is part of Canadian Forces or a person in a federal institution.	No further action required.	I
F6	This service was refused as the interpreting service provider billing number submitted is not a Radiologist service provider type.	If applicable, please make appropriate change and resubmit new claim.	R
F7	This service was refused as a Chiropractor is not acceptable as the referring service provider for this service.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q

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F8	This service was refused as a Pathologist is not generally acceptable as the referring service provider. If the referring provider number was incorrect submit a new claim with correction. If the referring provider was correct and re-assessment is required submit a formal query with supportive information.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
F9	A 50% premium was added to fee payable as patient is less than 2 years of age.	Claim raised to benefit level - no further action required.	I
F0	This service was refused as it was received after the date for which the approval of the time extension was granted.	No further action required.	I
G1	This service was refused as a valid chiropractic service code is required.	Please make appropriate change and resubmit new claim.	R
G2	This service was refused as a Chiropractor is not acceptable as a referring service provider type for consultations according to Rule of Application 7. If the referring provider number was incorrect submit a new claim with correction.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information	R/Q
G3	This service was refused as it requires a Technical Director provider number.	If applicable, please make appropriate change and resubmit new claim.	R
G4	This service was refused as unassigned completes and consultation benefit catalogue items cannot be claimed at this type of a facility.	If applicable, please make appropriate change and resubmit new claim.	R
G5	This service was refused as it is restricted to rural locations. The location of service/fee differential populated on the claim does not match this criteria.	If applicable, please make appropriate change and resubmit new claim.	R
G6	This service was refused as the number of patients submitted on the claim does not meet the criteria as outlined in the Physician's Manual.	If applicable, please make appropriate change and resubmit new claim.	R
G7	This service was refused as it cannot be claimed for a hospital in-patient. If patient was seen in the OPD, Emergency Dept or Clinic then mark O, E or C in the appropriate field.	If applicable, please make appropriate change and resubmit new claim	R
G8	This service was refused as total or technical components are not claimable when performed in a facility.	If applicable, please make appropriate change and resubmit new claim	R
G9	This service was refused as it requires a facility number.	If applicable, please make appropriate change and resubmit new claim.	R
G0	This service was refused as diagnostic radiological procedures require either a Technical Director billing number or a hospital facility number to be populated on the claim depending on the location where the service was rendered.	Please make appropriate change and resubmit new claim.	R
H1	This service was refused as a valid optometric reason code is required.	Please make appropriate change and resubmit new claim.	R
H2	This service was refused as the number of services submitted does not meet the required minimum as outlined in the Physician's Manual.	If applicable, please make appropriate change and resubmit new claim.	R

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H3	This service was rejected as it is excluded under the Reciprocal Billing Agreement. The patient can be billed directly for this service.	No further action required.	I
H4	This service was refused as it was not provided at an approved telemedicine site.	No further action required.	I
H5	This service was refused as the facility is not effective on this date of service.	If applicable, please make appropriate change and resubmit new claim	R
H6	This service was refused as complex lung function tests are only claimable when done in a designated facility which is under the direction of an appropriately trained service provider as outlined in the Physician's Manual.	No further action required.	I
H7	This service was refused as the Technical Director service provider number submitted is not valid.	Please make appropriate change and resubmit new claim.	R
H8	This service was refused as the Technical Director service provider number submitted is not effective on this date of service.	Please make appropriate change and resubmit new claim.	R
H9	This optometric service was rejected as it is excluded from coverage. For this service to be considered insured a patient of this age requires a medical reason approved by the Minister as stated in the *Optometric Services Insurance Regulation* .	If applicable, please make appropriate change and resubmit new claim.	R
H0	This service was refused as the ICD9 submitted does not coincide with the benefit catalogue item submitted.	If applicable, please make appropriate change and resubmit new claim.	R
I1	This service was refused as Dentists or Oral Surgeons are not acceptable as a referring service provider for this benefit catalogue item.	If applicable, please make appropriate change and resubmit new claim.	R
I2	This service was refused as it may only be claimed in a hospital or personal care home facility. The facility submitted is not approved for this benefit catalogue item.	If applicable, please make appropriate change and resubmit new claim.	R
I3	This service was rejected based on assessment of claim.	No further action required.	I
I4	This service was refused as it may only be claimed in a hospital facility. The facility submitted is not approved for this benefit catalogue item.	No further action required.	I
I5	This service was refused as it may only be claimed if provided in a designated facility. The facility submitted is not approved for this benefit catalogue item.	No further action required.	I
I6	This service was rejected as laboratory services rendered in this facility should not be submitted through the Medical Claims Program.	No further action required.	I

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I7	This service was rejected as it is not claimable in relation to services performed in a hospital, personal care home or other publically funded facility or a facility on contract with a Regional Health Authority to perform such insured services.	No further action required.	I
I8	This service was rejected as it is not payable when rendered in this type of facility.	No further action required.	I
I9	This service was rejected as injections or immunizations are generally not payable in a facility. If re-assessment is required a formal query must be submitted explaining why it was necessary for the service provider to give the injection.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
I0	This service has been refused as the age of the patient does not coincide with the ICD9 submitted. Submission of a new claim must include remarks supporting this diagnosis if ICD9 is confirmed to be correct.	If applicable, please make appropriate change and resubmit new claim.	R
J1	This service was refused as it may only be provided if rendered in the emergency department or out patient department of a hospital facility.	If applicable, please make appropriate change and resubmit new claim.	R
J2	This service was refused as it may only be claimed for a hospital in-patient or if rendered in the emergency department or out-patient department. If correction is made, submit a new claim with the original benefit catalogue item. If the location was correct on the original claim the appropriate complete history and physical examination benefit catalogue item may be submitted.	Please make the change and resubmit.	R
J3	This service was refused as it may only be claimed for in hospital in-patient or if rendered in the emergency department. If correction is made, submit a new claim with the original benefit catalogue item. If the location was correct on the original claim a consultation benefit catalogue item may be submitted.	If applicable, please make appropriate change and resubmit new claim.	R
J4	This service was refused as it may only be claimed for a hospital in-patient, a patient in a personal care home facility or if rendered in the emergency department.	Please make the change and resubmit.	R
J5	The service date has been changed based on assessment of the claim.	No further action required.	I
J6	This service was refused as the facility number provided is not valid.	If applicable, please make appropriate change and resubmit new claim.	R
J7	This service was rejected as eye muscle imbalance in adults is excluded from coverage unless certain criteria is indicated on the claim. If re-assessment is required submit a formal query with supportive information.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
J8	C99 - Condition must be specified in remarks section.	Please make appropriate change and resubmit new claim.	R

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J9	This service was refused as visits to a patient with an acute illness which occurs during a routine attendance at the facility must include the words "acute illness"‖in the remarks section of the claim according to Rule of Application 16. Submission of a new claim must include these remarks. If this was a routine visit for chronic care, benefit catalogue item 78511 would apply.	Please make appropriate change and resubmit new claim.	R
J0	This service was refused as it is not normally performed outside of a facility. If a facility was left blank in error a corrected claim may be submitted. If the service was performed outside of a facility and re-assessment is required, a formal query with supportive information should be submitted.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
K1	This service was refused as the optometric reason code submitted requires a medical condition. Submission of new claim must include this in remarks.	If applicable, please make appropriate change and resubmit new claim.	R
K2	This service was refused as By-Report benefit catalogue items require an operative report for surgical procedures or a descriptive report for non surgical services to be submitted with the claim in order to assess the correct payment of the procedure. Please include operative or descriptive report with submission of a new claim.	Please include the appropriate information and resubmit new claim.	R
K3	This service was refused as provisional services require an operative report for surgical procedures or a descriptive report for non surgical services to be submitted with the claim. Please include this in submission of a new claim.	Please include the appropriate information and resubmit new claim.	R
K4	This service was refused as the number of services submitted for the anesthetic premium is greater than the number of units billed for the Anesthetic Procedural Service.	If applicable, please make appropriate change and resubmit new claim.	R
K5	The number of services has been adjusted based on assessment of the claim.	No further action required.	I
K6	This service was refused as it may only be claimed for prostate or breast cancer. The ICD9 submitted does not support either of these conditions.	If applicable, please make appropriate change and resubmit new claim.	R
K7	This service was refused as the diagnosis given is not acceptable for this service. Please submit a new claim with an ICD9 appropriate to the patient's condition, complication or symptom or provide supportive information to assist us in assessing your claim.	If applicable, please make appropriate change and resubmit new claim.	R
K8	This service has been refused as the age of the patient does not coincide with the benefit catalogue item submitted. Submission of a new claim must include remarks supporting this benefit catalogue item if it is confirmed to be correct.	If applicable, please make appropriate change and resubmit new claim.	R
K9	This service has been rejected as it is excluded from coverage under *The Health Services Insurance Act.*	No further action required.	I

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K0	This service was rejected as the benefit catalogue item is incorrect for well baby care.	If applicable, please make appropriate change and resubmit new claim.	R
L1	This ICD9 indicates an unspecified disorder or condition. Please change the ICD9 to a more specific code or provide supportive information to assist us in assessing your claim.	Please make appropriate change and resubmit new claim.	R
L2	This team surgery service has been assessed accordingly.	No further action required.	I
L3	This service was refused as the referring service provider number is not effective on this date of service: a) if the referring service provider number was incorrect submit a new claim with the corrected number; b) if the consultation request was made prior to the referring service provider deletion date then submit a new claim with 4500 as the referring service provider number. The claim must include the full name of the service provider in the remarks section of the claim.	If applicable, please make appropriate change and resubmit new claim.	R
L4	This service was refused as the interpreting service provider number is not effective on this date of service. If the interpreting service provider number was incorrect submit a new claim with correction.	If applicable, Please make appropriate change and resubmit new claim.	R
L5	This service was rejected as it may only be claimed by designated service providers.	No further action required.	I
L6	This service is rejected as it cannot be claimed with the paid service for the treatment of warts or molluscum contagiosum. A new claim may be submitted with the appropriate visit fee under either benefit catalogue item 78540 or 78530.	Please make appropriate change and resubmit new claim.	R
L7	This service was rejected as certain benefit catalogue items listed in the Physician's Manual may only be claimed by specific service provider types. There is no approval on record for this service provider.	No further action required.	I
L8	Benefit catalogue item was added to claim based on manual assessment of claim.	No further action required.	I
L9	This service was refused as referring provider number 4000 requires the claim to include the full name and address including province of the provider in the remarks section of the claim. Please include these details in the submission of a new claim.	Please include the appropriate information and resubmit new claim.	R
L0	This service was refused as referring provider number 4500 requires the claim to include the full name of the provider in the remarks section of the claim. Please include these details in the submission of a new claim.	Please include the appropriate information and resubmit new claim.	R
M1	This service was rejected as our records indicate that this benefit catalogue item has been paid to another service provider on this date of service.	No further action required.	I

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M2	This service was rejected as our records indicate that this benefit catalogue item is under review or has been processed under the same or an alternate billing number on this date of service.	No further action required.	I
M3	This service was rejected as it is either included or incompatible with another benefit catalogue item paid for spine x-ray.	No further action required.	I
M4	Remarks are required stating site of culture. Please include this in the submission of a new claim.	Please include the appropriate information and resubmit new claim.	R
M5	This service was rejected as it is included in the benefit catalogue item paid for the related electrocardiogram.	No further action required.	I
M6	This service was rejected as the criteria as outlined in the Physician's Manual has not been met.	No further action required.	I
M7	This claim was refused. The service is not valid because of one or more of the following: a) The benefit catalogue item does not exist or does not exist under the prefix submitted; or b) The benefit catalogue item is not effective on this date of service; or c) The benefit catalogue item exists but is not acceptable under this providers speciality type of practice; or d) This service was rejected as it may only be claimed by designated service providers.	If applicable, please make appropriate change and resubmit new claim.	R
M8	This service was rejected as it is not generally acceptable under this service provider type.	No further action required.	I
M9	This claim was refused as the number of services cannot be zero or greater than 99.	Please make appropriate change and resubmit new claim.	R
M0	This claim was refused as anesthetic units cannot be greater than two digits.	Please make appropriate change and resubmit new claim.	R
N1	This service was refused as a "child" benefit catalogue item (add on) cannot be claimed without the corresponding "parent" benefit catalogue item or if the "parent" benefit catalogue item is refused or rejected.	No further action required.	I
N2	This service was rejected as the unilateral service is included in the benefit catalogue item paid for the bilateral procedure.	No further action required.	I
N3	This service was rejected as it is included in the benefit catalogue item paid for the related procedure.	No further action required.	I
N4	This service was rejected as a visit fee cannot be claimed at the same sitting with benefit catalogue item 23192.	No further action required.	I
N5	This service was rejected as cystoscopy is included in the benefit catalogue item paid.	No further action required.	I
N6	This service was rejected as it is included in the benefit catalogue item paid for botulinum toxin injections.	No further action required.	I
N7	This service was rejected as it was rendered within 6 weeks of the benefit catalogue item paid for radiotherapy teletherapy course of treatment.	No further action required.	I

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
N8	This service was rejected as it is included in the benefit paid for the related lung function test.	No further action required.	I
N9	This service was rejected as it is included in the benefit paid for the related audiogram.	No further action required.	I
N0	This service was rejected as a visit fee cannot be claimed with benefit catalogue item 34820.	No further action required.	I
O1	This service was rejected as a visit fee cannot be claimed with benefit catalogue item 34850.	No further action required.	I
O2	This service was rejected as a similar benefit catalogue item for this type of procedure has already been paid.	No further action required.	I
O3	This service was rejected as only one induction of labour benefit catalogue item may be paid per patient per delivery.	No further action required.	I
O4	This service was rejected as it is either included or incompatible with another benefit catalogue item paid for spine MRI.	No further action required.	I
O5	This service was rejected as it is either included or incompatible with another benefit catalogue item paid for breast sonography.	No further action required.	I
O6	This service was rejected as it is either included or incompatible with another benefit catalogue item paid for obstetrical sonography.	No further action required.	I
O7	This service was rejected as it is included in the benefit paid for surgical assistant within the 3 week post-op period.	No further action required.	I
O8	This service was rejected as it cannot be claimed on the same day as benefit catalogue item for ECT.	No further action required.	I
O9	This service was rejected as it cannot be claimed with the benefit catalogue item paid from the Neonatal and Paediatric Intensive Care, Comprehensive Care, or Ventilatory Support Fee Schedule.	No further action required.	I
O0	This service was rejected as it cannot be claimed on the same day with the benefit catalogue item paid for a consultation.	No further action required.	I
P1	This service was rejected as it cannot be claimed with the benefit catalogue item paid for sleep deprived recordings.	No further action required.	I
P2	This service was rejected as it cannot be claimed on the same day as the benefit catalogue item paid for psychotherapy.	No further action required.	I
P3	This service was rejected as it cannot be claimed with benefit catalogue item paid for weekly retainer.	No further action required.	I
P4	This service was rejected as live telemedicine, individual psychotherapy or psychiatric care cannot be claimed on the same day. One of these services was previously paid.	No further action required.	I

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
P5	This service was rejected as it is included in the benefit catalogue item paid for the anesthetic procedural services.	No further action required.	I
P6	This service was rejected as this independent procedure service cannot be claimed as it is an integral part of a total paid service.	No further action required.	I
P7	This service was rejected as diagnostic laparoscopy is included in the benefit catalogue item paid for a laparoscopic operative procedure.	No further action required.	I
P8	This service was rejected as it is included in the visit or examination benefit catalogue item paid.	No further action required.	I
P9	This service was rejected as local anesthetic is included in the paid procedure.	No further action required.	I
P0	This service was rejected as it cannot be claimed with the benefit catalogue item paid for manipulation.	No further action required.	I
Q1	This service was rejected as it is included in the benefit catalogue item paid for medical management.	No further action required.	I
Q2	This service was rejected as it cannot be claimed in addition to the benefit catalogue item paid for studies testing sleep disorders, overnight recording, telemetry or other ambulatory EEG monitoring.	No further action required.	I
Q3	This service was rejected as it is excluded from the benefit catalogue item paid.	No further action required.	I
Q4	This service was rejected as it cannot be claimed with the benefit catalogue item paid for renal failure.	No further action required.	I
Q5	This service was rejected as it cannot be claimed on the same day with the benefit catalogue item paid for patient controlled analgesia.	No further action required.	I
Q6	This service was rejected as it should be claimed as an added view.	Please include the appropriate information and resubmit new claim.	R
Q7	This service was rejected as a developmental assessment has already been paid on this date of service.	No further action required.	I
Q8	This service was rejected as a patient controlled analgesia has already been paid on this date of service.	No further action required.	I
Q9	This service was rejected as it cannot be claimed with the benefit catalogue item paid for neonatal/paediatric supportive care.	No further action required.	I
Q0	This service was rejected as it is included in the benefit catalogue item paid for Manitoba Home Nutrition Patient Conference.	No further action required.	I
R1	This service was rejected as it is included in the benefit catalogue item paid for palliative care counselling.	No further action required.	I

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
R2	This service was rejected as it cannot be claimed with the benefit catalogue item paid for patient care family conference.	No further action required.	I
R3	This service was rejected as it is included in the benefit catalogue item paid for the related immunization.	No further action required.	I
R4	This service was rejected as a feeding assessment has already been paid on this date of service.	No further action required.	I
R5	This service was rejected as individual psychotherapy and psychiatric care cannot be claimed on the same day by the same psychiatrist. One of these services was previously paid.	No further action required.	I
R6	This service was rejected as technical or professional services are included in the benefit catalogue item paid for the related total benefit.	No further action required.	I
R7	This service was rejected as it is incompatible with the benefit catalogue item paid for sleep studies that was provided to this patient on this date of service by the same or different service provider.	No further action required.	I
R8	This service was rejected as a special call is not payable under these circumstances.	No further action required.	I
R9	This service was rejected as our records indicate that a paid hepatitis immunization benefit catalogue item exists for this date of service. If both hepatitis A and B were provided a formal query must be submitted for re-adjudication.	Please submit a formal query with supportive information.	Q
R0	This service was rejected as a single photon emission computerized tomography service has already been paid on this date of service.	No further action required.	I
S1	This service was rejected as it is included in the benefit catalogue item paid for the related scan.	No further action required.	I
S2	This service was rejected as it is incompatible with the benefit catalogue item paid for the related test.	No further action required.	I
S3	This service was rejected as it is included in the benefit paid for the related nerve conduction study.	No further action required.	I
S4	This service was rejected as it is included within 72 hours of the benefit paid for the anesthesia consultation.	No further action required.	I
S5	This service was rejected as it is included in the benefit catalogue item paid for the related ergometer exercise test.	No further action required.	I
S6	This service was rejected as it is included in the benefit catalogue item paid for the related test.	No further action required.	I
S7	This service was rejected as there is no indication on the claim that the visit was rendered prior to admission. If patient was seen in the OPD, Emergency Dept or Clinic prior to admission then mark O, E or C in the appropriate field.	If applicable, please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
S8	This service was rejected as it cannot to be claimed with benefit catalogue item 25612 as there was not another second major procedure paid on this date of service.	No further action required.	I
S9	This service was rejected as there is no record of an anesthetic procedural service on this date of service. If the pre-anesthetic evaluation was completed and there was a delay in surgery, please submit a new claim with benefit catalogue item 78508.	If applicable, please make appropriate change and resubmit new claim.	R
S0	This service was rejected as there is no record of the corresponding cardiac electrophysiology service paid on this date of service. Please check your records and if required contact the surgeon for confirmation of claim details.	If applicable, please make appropriate change and resubmit new claim.	R
T1	This surgical assist service was rejected as our records indicate that the corresponding surgical procedure has been paid under this billing number. If the surgical procedure was billed in error a formal query must be submitted for re-adjudication.	Please submit a formal query.	Q
T2	This service was rejected as the surgical assist benefit is less than the required minimum to qualify for a surgical assist fee.	Please submit a formal query.	Q
T3	This service was refused as supportive information is required for multiple local anesthetic injections when there is no procedure claimed on this date of service.	If applicable, please provide required information and resubmit new claim.	R
T4	This service was rejected as it is included in the benefit paid to another service provider for the related lung function test.	No further action required.	I
T5	This service was rejected as it is included in the benefit paid to another service provider for the related procedure.	No further action required.	I
T6	This service was rejected as it is included in the benefit paid to another service provider for the related audiogram.	No further action required.	I
T8	This claim was refused as the billing number submitted is for a technical director and cannot be used as the billing service provider.	Please make appropriate change and resubmit new claim.	R
T9	This service was rejected as the frequency limit of one chronic disease/comprehensive care management per year has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
T0	The benefit amount for this repeat procedure has been assessed according to Rules of Application 29, 38, 39, 40 and 43.	No further action required.	I

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
U1	The benefit amount for this multiple procedure has been assessed according to Rules of Application 25, 26, 27, 36 and 37.	No further action required.	I
U2	The benefit amount for this bilateral procedure has been assessed according to Rule of Application 28 or note in Physician's Manual.	No further action required.	I
U3	This service was rejected as a communication benefit catalogue item cannot be claimed on the same day as other medical services.	No further action required.	I
U4	This service was rejected as it is included in the benefit paid for the procedure.	No further action required.	I
U5	This service was rejected as this cast benefit is included within 3 weeks of the benefit paid for the surgical procedure.	No further action required.	I
U6	This service has been rejected in accordance with Rule of Application 23.	No further action required.	I
U7	This service was rejected as it cannot be claimed on the same day as hospital care.	No further action required.	I
U8	This service was rejected as this visit fee is included in the benefit paid for the procedure.	No further action required.	I
U9	This service was rejected as it is included within 6 weeks of the benefit paid for the related radiotherapy teletherapy by the same or different service provider.	No further action required.	I
U0	This service was rejected as another service provider has been paid for a related visit benefit for the same or similar condition. If re-assessment is required submit a formal query with supportive information.	Please submit a formal query with supportive information.	Q
V1	This service was rejected as our records indicate that a visit or examination has been paid on this date of service. If re-assessment is required submit a formal query with supportive information.	Please submit a formal query with supportive information.	Q
V2	This service was rejected as a local anesthetic is not generally billed with this type of service. If re-assessment is required submit a formal query with supportive information.	Please submit a formal query with supportive information.	Q
V3	This service was rejected as a group psychotherapy session for a different group size has already been paid on this date of service.	No further action required.	I
V4	This service was rejected as it has been less than 6 months since a comprehensive cognitive assessment was paid. A new claim may be submitted with the appropriate visit benefit catalogue item.	If applicable, please make appropriate change and resubmit new claim.	R
V5	This service was rejected as technical or professional services are included in the benefit paid for the total benefit paid to a different service provider on this date.	No further action required.	I

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
V6	This service was rejected as it is included in the benefit paid for the related nerve conduction study provided to this patient on this date of service by a different service provider.	No further action required.	I
V7	This service was rejected as it is included in the benefit paid for the related test provided to this patient on this date of service by a different service provider.	No further action required.	I
V8	This preoperative care service was rejected as it is included in the benefit paid for the surgical procedure.	No further action required.	I
V9	This service was rejected as the frequency limit of one plasmapheresis per year has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
V0	This service was rejected as the frequency limit of one botulinum toxin injection per 12 weeks has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
W1	This service was rejected as the frequency limit of 1 stipend or retainer per week has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
W2	This service was rejected as the frequency limit of 1 complete or extensive re-examination of a cancer patient per 21 days has been reached. A new claim may be submitted with the appropriate benefit catalogue item.	No further action required.	I
W3	This service was rejected as the frequency limit of 1 service per 21 days has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
W4	This service was rejected as our records do not show that an initial hemodialysis claim has been received within the preceding four weeks. Rule of Application 44 applies.	No further action required.	I
W5	This service was rejected as the frequency limit of 1 initial peritoneal dialysis within 2 weeks has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
W6	This service was rejected as the frequency limit of 1 service per 2 weeks has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
W7	This service was rejected as the frequency limit of 1 service with supervision per 6 months has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I
W8	This service was rejected as the frequency limit of 1 service per 12 months has been reached. This service has been paid to you or another service provider during this time span for this patient.	No further action required.	I

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
W9	This service was rejected as the frequency limit of 1 complete history and physical examination per 60 days for the same condition has been reached. A new claim may be submitted with the appropriate benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
W0	This service was rejected as our records indicate that you have rendered a complete history and physical examination in respect to this patient within the last 12 consecutive months prior to this date of service. A new claim may be submitted with the appropriate benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
X1	This service was rejected as our records indicate that you have rendered a consultation in respect to this patient within the last 12 consecutive months prior to this date of service. A new claim may be submitted with the appropriate benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
X2	This service was rejected as our records indicate that you have rendered an unassigned consultation in respect to this patient within the last 12 consecutive months prior to this date of service. A new claim may be submitted with the appropriate benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
X3	This service was rejected as our records indicate that you have rendered a complete history and physical examination in respect to this patient within the last 12 consecutive months prior to this patient's admission to hospital. A new claim may be submitted with the appropriate benefit catalogue item for admission.	Please make appropriate change and resubmit new claim.	R
X4	This service was rejected as a consultation for the same, similar or related medical condition may only be claimed once within a 12 consecutive month period as per Rule of Application 10. A new claim may be submitted with the appropriate benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
X5	This claim was refused as the PHIN is: a) blank or b) invalid.	Please make appropriate change and resubmit new claim.	R
X6	This claim was refused as the Health ID for this non-resident is:. a) blank or b) invalid.	Please make appropriate change and resubmit new claim.	R
X7	This service was processed in accordance with a Medical Officer Assessment.	No further action required.	I
X8	This service was refused as the medical necessity was not substantiated and is required when claimed for this diagnosis under the *Excluded Services Regulation* .	Please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
X9	This service was rejected as the referring service provider is not listed in the Manitoba College of Physicians and Surgeons Directory.	No further action required.	I
X0	This service was processed in accordance with advice of a practicing service provider consultant in the relevant service provider type.	No further action required.	I
Y1	This service was rejected as it is the responsibility of WCB and should be submitted directly to WCB.	No further action required.	I
Y2	This service was rejected as there is no prior approval on record.	No further action required.	I
Y3	The benefit fee has been increased based on the assessment of claim.	No further action required.	I
Y4	The benefit fee has been reduced based on the assessment of claim.	No further action required.	I
Y5	This service was rejected according to Rule of Application 6. A new claim may be submitted with the appropriate subsequent benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
Y6	The benefit fee has been adjusted based on approval from the Cleft Palate Program.	No further action required.	I
Y7	This service was refused as additional supportive information is required. Submission of new claim must include both the name of the drugs and an indication that two or more separate communications occurred on the same service in the remarks.	Please make appropriate change and resubmit new claim.	R
Y8	The remarks appear to indicate that service was a communication for prescription renewal and claimable as Communication benefit catalogue item 78005. If the patient was seen on the same day for another medical service, benefit catalogue item 78005 is not payable in addition. Please submit a new claim with the appropriate benefit catalogue item.	If applicable, please make appropriate change and resubmit new claim.	R
Y9	This service was rejected as it is included in the benefit paid for detention time.	No further action required.	I
Y0	This service has been rejected as services performed at the request of a third party are excluded from coverage under *The Health Services Insurance Act* .	No further action required.	I
Z1	Uninsured immunizations cannot be submitted through the Medical Claims System to update the provincial vaccine registry. Contact your local Public Health office.	No further action required.	I
Z2	This service was refused as the treatment location of clinic, emergency or outpatient is not acceptable for this benefit catalogue item.	No further action required.	I

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
Z3	This service was refused as a visit fee cannot be claimed in addition to the allergy injection unless the claim contains supportive information as outlined in the Physician's Manual. Submission of a new claim must include remarks.	If applicable, please include the appropriate information and resubmit new claim.	R
Z4	This psychotherapy service was refused as the ICD9 submitted is not applicable for this service. If the ICD9 was incorrect a corrected claim may be submitted with the original benefit catalogue item. If the ICD9 was correct a new claim should be submitted with the appropriate benefit catalogue item.	If applicable, please make appropriate change and resubmit new claim.	R
Z5	This service was refused as the date or time of service does not correspond with the premium benefit billed.	No further action required.	I
Z6	This service was refused as the ICD9 submitted does not match the diagnosis of the specific chronic disease management benefit catalogue item.	If applicable, please make appropriate change and resubmit new claim.	R
Z7	This service was refused as a valid ICD9 code is required. An ICD9 code is considered invalid if it is not coded up to the full number of digits. As an example 402.0 is not considered a valid ICD9 code without the fifth digit.	Please include the appropriate information and resubmit new claim.	R
Z8	This claim was refused as the referring service provider is: a) blank or b) invalid.	If applicable, please make appropriate change and resubmit new claim.	R
Z9	This claim was refused as the interpreting service provider is: a) blank or b) invalid.	Please include the appropriate information and resubmit new claim.	R
Z0	This service was refused as supportive information is required for multiple services in the form of remarks unless the service was performed bilaterally or at different times. In those cases populate the appropriate field in lieu of a remark. Submission of a new claim should include this information.	Please include the appropriate information and resubmit new claim.	R
1A	This service was refused as the location of service/fee differential populated on the claim is not acceptable for services rendered in the Winnipeg hospital facility indicated on the claim.	Please make appropriate corrections and resubmit new claim.	R
1B	This service was refused as the location of service/fee differential populated on the claim is not acceptable for Pre-Operative Anaesthesia Clinics (Preana Clinic).	No further action required.	I
1C	The number of services has been adjusted to reflect the maximum allowed.	No further action required.	I

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
1D	The number of services or units has been adjusted to reflect the maximum frequency limitation allowed.	No further action required.	I
1E	The service was rejected as the frequency limit has been reached.	No further action required.	I
1F	This service was rejected as there is no approval on file under the Technical Director provider number submitted on the claim.	No further action required.	I
1G	This service was rejected as the referring service provider must be a GP or RN (EP). If the referring service provider number was incorrect submit a new claim with correction.	If applicable, please make appropriate change and resubmit new claim.	R
1H	This benefit was refused as an Optometrist is not acceptable as a referring service provider for this benefit.	No further action required.	I
1I	The number of services for this date span benefit has been adjusted as the service recipients coverage was not in effect for the entire date span.	No further action required.	I
1J	This service was rejected as the benefit catalogue item submitted is incorrect for the service performed. This service is included in the examination benefit catalogue item paid.	No further action required.	I
1K	This service was rejected as the benefit submitted is incorrect for the service performed. There is no benefit catalogue item for this service. A new claim may be submitted with the appropriate visit fee.	Please make appropriate change and resubmit new claim.	R
1L	The premium amount has been adjusted based on the reduced payable amount of eligible benefits.	No further action required.	I
1M	This claim was refused as the start time is: a) blank or b) invalid.	Please make appropriate change and resubmit new claim.	R
1N	This claim was refused as the stop time is: a) blank or b) invalid.	Please make appropriate change and resubmit new claim.	R
1O	This service was refused as additional supportive information is required. Submission of new claim should include the type of dental surgery within the remarks section of the claim. Note that if the dental surgery is not insured by Manitoba Health the pre-operative exam will also be excluded.	Please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
1P	This service was refused as the benefit billed seems incorrect for the diagnosis of skin tags or warts. If the skin tag or wart was excised and closed then supportive information is required. Submission of new claim must include remarks indicating this or a procedural report. If cautery destruction or simple surgical excision was performed then a new claim may be submitted with the appropriate benefit catalogue item for this service.	Please make appropriate change and resubmit new claim.	R
1Q	This service was refused as the diagnosis of acne is not sufficient for benefit catalogue item 78473 unless the discussion pertained to the use of Accutane. Submission of new claim must include remarks indicating this.	Please make appropriate change and resubmit new claim.	R
1R	Query processed as requested by provider.	No further action required.	I
1S	Submission of new claim under correct billing service provider number is required.	Please make appropriate change and resubmit new claim.	R
1T	Submission of new claim under correct patient is required.	Please make appropriate change and resubmit new claim.	R
1U	The maximum payable has been reduced to match the approval on file.	No further action required.	I
1V	This service was refused as the benefit prefix is incorrect.	Please make appropriate change and resubmit new claim.	R
1W	This claim has been refused as the service provider had a payment option change within the service date span for benefits submitted on the claim. Resubmission of two separate claims is required based on each payment option. Contact Practitioner Registry to verify the payment option date change and re-submit benefits accordingly.	Please make appropriate change and resubmit new claim.	R
1X	This service was refused as the visit benefit requires a medical condition when billed in addition to a psychotherapy benefit. Please submit a new claim with an ICD9 appropriate to the patient's medical condition.	Please make appropriate change and resubmit new claim.	R
1Y	This service was refused as a special call cannot be claimed with the benefit catalogue item paid for a routine visit to a chronic care patient.	No further action required.	I
1Z	This service was rejected as it cannot be claimed with the benefit catalogue item paid for Hyperacute Stroke Services.	No further action required.	I
2A	This service was rejected as it may only be claimed within 24 hours of benefit 78485.	No further action required.	I
2B	This service was rejected as it is incompatible with the benefit catalogue item paid under 89237. When both of these services are provided the correct catalogue item is 89280.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
2C	This service was rejected as it is incompatible with the benefit catalogue item paid under 89279. When both of these services are provided the correct catalogue item is 89280.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
2D	This service was refused as the diagnosis given is not acceptable for this service. Please submit a new claim with an ICD9 appropriate to the patient's condition.	Please make appropriate change and resubmit new claim.	R
2E	This service was refused as it does not apply to special calls made to a newborn.	Please make appropriate change and resubmit new claim.	R
2F	This service was refused as the supportive information provided does not support the number of services billed.	Please make appropriate change and resubmit new claim.	R
2G	This service was refused as the supportive information provided does not correspond with the benefit billed.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
2H	This service was refused as the time given does not correspond with the number of services billed.	Please make appropriate change and resubmit new claim.	R
2I	This service was refused as the time given does not correspond with the premium benefit billed.	No further action required.	I
2J	This service was refused as referring provider number 4500 requires the claim to include the full name of the provider in the remarks section of the claim. If the telemedicine service was set up by a health care provider other than a physician or RNEP their name and position should be provided in remarks. Please include these details in the submission of a new claim.	Please make appropriate change and resubmit new claim.	R
2K	This service was refused as the supportive information provided does not correspond with the optometric reason code billed.	Please make appropriate change and resubmit new claim.	R
2L	The number of services for this date span benefit has been adjusted as this service is included in another visit benefit catalogue item paid.	No further action required.	I
2M	This service was refused as the diagnosis given is not acceptable for this service. Please submit a new claim with an ICD9 appropriate to the patient's complication of labour or pregnancy.	Please make appropriate change and resubmit new claim.	R
2N	This related post fracture service was rejected as it is included within 3 weeks in the benefit paid for fracture according to Rule of Application 34.	No further action required.	I
2O	This service was refused as the requested operative or descriptive report was not submitted to our office. Please include this in submission of a new claim.	Please make appropriate change and resubmit new claim.	R
2P	This service was refused as the service date for this benefit does not match the report submitted. Please make correction on either the claim or the report and include this in submission of new claim.	Please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
2Q	This anesthetic or surgical assistant service was rejected as the benefit submitted does not match the surgical benefit claimed by the surgeon.	No further action required.	I
2R	This anesthetic or surgical assistant service was added to match the surgical benefit claimed by the surgeon.	No further action required.	I
2S	This service was refused as it may only be claimed in a Clinical Teaching Unit.	No further action required.	I
2T	This service was refused as type of provider is not acceptable as a referring service provider for this benefit catalogue item.	No further action required.	I
2U	This service was rejected as it cannot be claimed with the benefit catalogue item paid for geriatric specialty support.	No further action required.	I
2V	This service was rejected as it cannot be claimed with the benefit catalogue item paid for pediatric supportive care.	No further action required.	I
2W	This service was rejected as the referring service provider must be a Psychiatrist. If the referring service provider number was incorrect submit a new claim with correction.	Please make appropriate change and resubmit new claim.	R
2X	This service was rejected as the referring service provider must be a General Practitioner or Paediatrician. If the referring service provider number was incorrect submit a new claim with correction.	Please make appropriate change and resubmit new claim.	R
2Y	This service was rejected as other communication benefits cannot be claimed on the same day as Psychiatrist to General Practitioner or Paediatrician telephone conversations.	No further action required.	I
2Z	This service was refused as this type of provider is not acceptable as a billing service provider.	No further action required.	I
3A	This service was rejected as other communication benefits cannot be claimed within the 7 day period of a weekly retainer.	No further action required.	I
3B	This service was rejected as it must be performed in a facility under general anesthesia. The facility was either blank or invalid.	Please make appropriate change and resubmit new claim.	R
3C	This service was refused as the ICD9 given must indicate a second or third degree burn.	No further action required.	I
3D	This service was refused as ICD9 given does not meet the Guidelines for Anesthesia Consultations.	No further action required.	I
3E	This service was refused as referring service provider number submitted is incorrect. This provider has a personal billing number. Submission of new claim should include this number in the appropriate field.	Please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
3F	This service was refused as a child benefit catalogue item (add on) cannot be claimed for surgical assists. A new claim may be submitted with the corrected surgical assist benefit.	Please make appropriate change and resubmit new claim.	R
3G	This service was rejected as this conference cannot be claimed within the same 7 day period as the weekly retainer for management of home TPN patient.	No further action required.	I
3H	This claim was refused as start times must be populated on all benefits submitted on the same claim as a premium benefit code.	Please make appropriate change and resubmit new claim.	R
3I	This claim was refused as the teaching facility submitted does not correspond with the electronic fund transfer information on file.	Please make appropriate change and resubmit new claim.	R
3J	This service was refused as the maximum number of services for this benefit is 1 unless the service was performed bilaterally. If performed bilaterally, the number of services should be submitted as 2, and the bilateral indicator populated in the appropriate field. If performed at different times, on the same day, each service must be submitted on separate lines with the start time populated for each line item in the appropriate field.	Please make appropriate change and resubmit new claim.	R
3K	This service was refused as the maximum number of services for this benefit is 1. If performed at different times, on the same day, each service must be submitted on separate lines with the start time populated for each line item in the appropriate field.	Please make appropriate change and resubmit new claim.	R
3L	The number of services has been adjusted to the maximum allowed based on the corresponding number of services for the processed parent benefit(s).	No further action required.	I
3M	This benefit was previously assessed by our Medical Officer. Based on a review of the information provided - no adjustment will be made.	No further action required.	I
3N	This service has been rejected. Only one initial comprehensive pre-natal assessment may be claimed per pregnancy per physician.	No further action required.	I
3O	This service has been rejected according to Rule of Application 46.	No further action required.	I
3P	This service has been rejected based on a request from the billing provider or the user site.	No further action required.	I

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
3Q	This service was refused. Additional services with the same benefit code, which occur on the same day, must be submitted on separate lines. The start time must be populated for each line item in the appropriate field. Remarks should also be provided where there is additional information that may assist in the adjudication of the services.	Please make appropriate change and resubmit new claim.	R
3R	Premiums are not payable in these circumstances for the other benefit items on the claim.	No further action required.	I
3S	The number of services has been adjusted according to Rule of Application 12.	No further action required.	I
3T	This service was refused. Additional services for psychotherapy sessions that extend beyond the limit must be submitted with supporting remarks.	Please make appropriate change and resubmit new claim.	R
3U	This service was refused as the maximum number of services for this procedures is 1 unless the service was performed bilaterally. If performed bilaterally, the number of services should be submitted as 2, and the bilateral indicator populated in the appropriate field.	Please make appropriate change and resubmit new claim.	R
3V	This claim was refused as only one type of premium service may be submitted per claim.	Please make appropriate change and resubmit new claim.	R
3W	This service was refused as we require an operative report for surgical procedures or a descriptive report for non surgical services to be submitted with the claim in order to assess the correct payment of the procedure. Please include operative or descriptive report with submission of a new claim.	Please make appropriate change and resubmit new claim.	R
3X	This service was refused. Additional services with the same benefit code, which occur on the same day, must be submitted on separate lines. The start time must be populated for each line item in the appropriate field.	Please make appropriate change and resubmit new claim.	R
3Y	This service was refused as supportive information is required indicating the site of the injection in the form of remarks If the service was performed bilaterally populate the appropriate field in addition to the remark. Submission of a new claim should include this information.	Please make appropriate change and resubmit new claim.	R
3Z	This service was refused as it is not acceptable in a facility.	Please make appropriate change and resubmit new claim.	R
4A	This service was refused as supportive information is required for multiple services in the form of remarks. Submission of a new claim should include this information.	Please make appropriate change and resubmit new claim.	R
4B	This service was refused as the ICD9 given is identical to a similar paid procedure. Supportive information is required in the form of remarks. Submission of a new claim should include this information.	Please make appropriate change and resubmit new claim.	R
4C	This service was refused as it should be claimed under the benefit code for the second or additional lesion resection.	Please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
4D	This service was refused as the number of services claimed exceeds the allowable remaining limit within the time frame specified in the Physician's Manual. Supportive information is required in the form of remarks for these services to be considered. Submission of new claim should include this information.	Please make appropriate change and resubmit new claim.	R
4E	This service was refused as the limit per knee has been reached.	Please make appropriate change and resubmit new claim.	I
4F	This service was refused as it includes a comprehensive pelvic examination. Generally this type of exam would not be performed for a patient with this condition or complication.	Please make appropriate change and resubmit new claim.	R
4G	This sevice was refused according to Rule of Application 12.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
4H	This service was refused according to Rule of Application 12. Another service provider has been paid for one or more of the days billed.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
4I	This service was refused as one or more of the days billed are duplicates. Please check your records and re-submit only the service dates that have not been paid.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
4J	(RNEP/Dentist) This service was refused. Another service provider has been paid for one or more of the days billed.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
4K	This service was refused according to Rule of Application 14 and 48. Another service provider under the same specialty has been paid for one or more of the days billed.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
4L	The service was refused as the benefit catalogue item billed is not supported by the information provided.	No further action required.	I
4M	This service was refused as the number of anesthetic units does not match the total time billed.	Please make appropriate change and resubmit new claim.	R
4N	This service was rejected as it is not currently insured under the Provincial Health Plan.	No further action required.	I
4O	This service does not require prior approval, and should not be submitted with the prior approval indicator populated.	No further action required.	I
4P	This service was refused as the patient's claim history indicates that no services have been provided under this billing number in the past 12 months. Please check your records.	No further action required.	I
4Q	This service was refused. Biopsies performed for this condition should be billed under benefit code 20171. Please submit a new claim with the appropriate benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
4R	This service was refused as benefit 78001 is not supported by the information provided. Benefit 78001 is not payable for communication of test results.	No further action required.	I

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
4S	This service was rejected as our records indicate that this benefit catalogue item has been paid to another service provider.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
4T	This service was rejected in accordance with the Manitoba Physician's Manual. Please refer to the Interventional Cardiology Billing Bulletin found on the Claims Processing System (CPS) webpage for more information.	No further action required.	I
4U	This service was rejected as the frequency limit has been reached. Services may have been paid to you or another service provider.	No further action required.	I
4V	This service was refused according to Rule of Apllication 44.	No further action required.	I
4W	This claim was refused as the premium billed is incorrect for anesthesia services. A new claim may be submitted with the corrected premium benefit.	Please make appropriate change and resubmit new claim.	R
4X	This service was rejected as our records indicate there is no enrollment record for this patient with this service provider.	No further action required.	I
4Y	This service was rejected as the date of service is outside of the effective date of the enrollment record.	No further action required.	I
4Z	This service was refused as the patient's claim history indicates that there has not been ongoing comprehensive care provided under this billing number. Please check your records.	No further action required.	I
5A	This service was rejected according to Rule of Application 8. A new claim may be submitted with the appropriate subsequent benefit catalogue item.	Please make appropriate change and resubmit new claim.	R
5B	This service was rejected as it cannot be claimed consecutively for more than one day of treatment.	Please make appropriate change and resubmit new claim.	R
5C	This benefit was rejected as it is incorrect for the service performed. Gynecological examination benefits exist that include the cytological smear. Please resubmit with the correct gynecological exam that includes the cytological smear.	Please make appropriate change and resubmit new claim.	R
5D	This service was rejected as nerve blocks cannot be claimed in addition to surgical procedures. As per the Physician's Manual, nerve blocks are only payable as an isolated service for diagnostic or therapeutic purposes.	No further action required.	I
5E	This benefit was rejected as it is not applicable when billed for oral surgery anesthesia. The correct benefit for oral surgery anesthesia is 46999. A new claim may be submitted using the correct benefit code.	Please make appropriate change and resubmit new claim.	R
5F	This service was rejected as the location of service/fee differential populated on the claim does not correspond with the facility location.	Please make appropriate change and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

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	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
5G	This service was rejected as our records indicate that this benefit code has been recently paid. Submission of a new claim must include remarks supporting the second or repeat procedure.	Please make appropriate change and resubmit new claim.	R
5H	This service was rejected as it is included in the benefit catalogue item paid for 24 hour supervision.	No further action required.	I
5I	This service was refused according to Rules of Application 14 and 48.	No further action required.	I
5J	This benefit was previously assessed by our Medical Officer. If re-assessment is required submit a formal query with additional information for review.	Please make appropriate change and resubmit new claim or submit a formal query with supportive information.	R/Q
5K	This service was rejected according to Rule of Application 47.	Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.	I
5L	This service was refused as the diagnosis given is not acceptable for this service.	If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.	R/Q
5M	This benefit was refused as supportive information listing the benefit codes for the multiple or bilateral exams performed, must be provided in the form of remarks or a detailed report.	Please make appropriate corrections and resubmit the claim.	R
5N	This claim was refused as the remarks indicate a Split surgery. A new claim must be submitted with **"S"** populated in the special circumstances indicator field on each line. If submitting a surgical assistant's service in addition, please be sure the benefit for the surgical assistant is billed with a prefix "0".	Please make appropriate corrections and resubmit new claim.	R
5O	This x-ray benefit has been rejected. For an x-ray of two areas of the spine, the correct benefit is 57037. For an x-ray of three areas of the spine (complete spine), the correct benefit is 57035. A new claim should be submitted using the correct benefit code.	Please make appropriate corrections and resubmit new claim.	R
5P	The benefit has been assessed at a percentage as per note in the Physician's Manual.	No further action required.	I
5Q	This service was refused as the ICD9 submitted is age specific and is incorrect for a patient of this age.	Please make appropriate corrections and resubmit new claim.	R
5R	This benefit code was refused as it is restricted to Winnipeg locations. The location of service/fee differential populated on the claim does not meet this criteria.	Please make appropriate corrections and resubmit new claim.	R

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
5S	This service has been rejected according to Rule of Application 44. Please check your records and re-submit as repeat dialysis for chronic renal failure.	Please make appropriate changes and resubmit the claim.	R
5T	This service was rejected as only one dialysis service is payable per day. This service has been paid to you or another provider for this patient.	No further action required.	I
5U	This service appears incorrect as an initial dialysis should not follow a subsequent dialysis. If re-assessment is required submit a formal query with supportive information.	If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.	R/Q
5V	This service was rejected as it cannot be claimed within the 7 day period of a weekly retainer.	No further action required.	I
5W	This service was rejected. Please re-submit your claim using the appropriate benefit code for this service.	Make appropriate changes and re-submit the claim.	R
5X	This service was rejected as this immunizing agent is not currently available in Manitoba.	Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.	I
5Y	This service was refused as benefit 23577 applies at the initial operation for trauma only. Our records indicate that benefit 23577 has previously been paid to you or another provider for this patient.	Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.	I
5Z	This service was rejected as the criteria for claiming this virtual visit has not been met.	Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.	I

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
6A	This patient's health coverage has been reinstated. This claim has been processed accordingly.	Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.	I
6B	Claim reversal: Claim was reversed due to Manitoba Finance Audit.	Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.	I
6C	Remarks are required when a premium benefit code is submitted without other benefits on same claim.	Make appropriate changes and re-submit the claim.	R
6D	This claim was refused as the premium billed is incorrect for non-anesthesia related services. A new claim may be submitted with the corrected premium benefit.	Make appropriate changes and re-submit the claim.	R
6E	This service was rejected as it cannot be claimed on the same day as a telephone/video conference(s).	No further action required.	I
6F	This service was refused as it is only claimable when rendered for an in-patient service in a hospital.	No further action required.	I
6G	Age premium applied.	No further action required.	I
6H	Hospital care premium applied.	No further action required.	I
6I	This claim was refused as the benefit catalogue item or PHIN submitted is not correct for Indirect Clinical Services.	No further action required.	I
6J	The location of service/fee differential populated on the claim applies to virtual services only. This claim has been processed accordingly.	No further action required.	I
6K	This claim is refused as only one extended clinic hours premium benefit may be submitted per claim.	No further action required.	I
DR	Previously paid service has been withdrawn.	No further action required.	I

Explanation of Benefit Codes (EOBs)

LEGEND:	Action Type R (Resubmit): Make appropriate changes and re-submit the claim.
	Action Type I (Information): Information only, or update your records accordingly. NOTE: For many claims, an update to your records will be required for future claims submission. In other instances, the claim may require further action. If the claim data submitted was correct, then no further action is required. If the claim data was incorrect, then the claim may require correction and resubmission.
	Action Type Q (Query): Submit a formal query.
	R/Q: If the claim data submitted was incorrect, submit a new claim with correction. If the claim data submitted was correct and re-assessment is required, submit a formal query with supportive information.
	NOTE: All claims (including resubmitted claims) must be received by MH within 6 months from the date the service was rendered.

EOB	EOB DESCRIPTION	ACTION DESCRIPTION	ACTION TYPE
CR	Credit service adjustment.	No further action required.	I
33	Maximum automated haematology benefit limit has been reached and the fee was assessed accordingly.	No further action required.	I
34	Maximum automated biochemistry benefit limit has been reached and the fee was assessed accordingly.	No further action required.	I
40	Letter of written explanation to follow.	Follow instructions in letter.	
41	Benefit catalogue item has been returned unprocessed as it was submitted on the same claim as another benefit catalogue item that was rejected. This resulted in a full claim rejection. Please refer to the other EOB codes on this claim. Once corrections have been addressed a new claim may be submitted.	Please make appropriate corrections and resubmit new claim.	R
44	This claim was refused as the patient's demographics submitted does not match our information under this PHIN.	Please make appropriate change and resubmit new claim.	R
52	The benefit fee has been adjusted to the laboratory cap level.	No further action required.	I
57	The benefit amount for this multiple procedure has been assessed according to Rule of Application 3 for oral surgery benefits.	No further action required.	I
58	The benefit amount for this procedure has been assessed according to Rule of Application 1 or 2 for oral surgery benefits.	No further action required.	I
77	Pending benefit catalogue item.	No further action required - claim will be processed on a future remittance.	I
96	Interest has been applied to this service	No further action required.	I