Code	Description
X0	Supplemental Messages
A0	Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.
A1	Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
A2	Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.
A3	Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.
A4	Acknowledgement/Not Found-The claim/encounter can not be found in the adjudication system.
A5	Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system.
A6	Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.
A7	Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.

A8	Acknowledgement / Rejected for relational field in error.
P0	Pending: Adjudication/Details-This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.
P1	Pending/In Process-The claim or encounter is in the adjudication system.
P2	Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, repricing, Third Party Administrator processing).
P3	Pending/Provider Requested Information - The claim or encounter is waiting for information that has already been requested from the provider. (Note: A Claim Status Code identifying the type of information requested, must be reported)
P4	Pending/Patient Requested Information - The claim or encounter is waiting for information that has already been requested from the patient. (Note: A status code identifying the type of information requested must be sent)
P5	Pending/Payer Administrative/System hold
F0	Finalized-The claim/encounter has completed the adjudication cycle and no more action will be taken.
F1	Finalized/Payment-The claim/line has been paid.
F2	Finalized/Denial-The claim/line has been denied.

F3	Finalized/Revised - Adjudication information has been changed
F3F	Finalized/Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a subsequent entity as identified on the original claim or in this payer's records.
F3N	Finalized/Not Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made. The claim/encounter has NOT been forwarded to any subsequent entity identified on the original claim.
F4	Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming.
F5	Finalized/Cannot Process
R0	Requests for additional Information/General Requests-Requests that don't fall into other R-type categories.
R1	Requests for additional Information/Entity Requests-Requests for information about specific entities (subscribers, patients, various providers).
R3	Requests for additional Information/Claim/Line-Requests for information that could normally be submitted on a claim.
R4	Requests for additional Information/Documentation-Requests for additional supporting documentation. Examples: certification, x-ray, notes.
R5	Request for additional information/more specific detail-Additional information as a follow up to a previous request is needed. The original information was received but is inadequate. More specific/detailed information is requested.

R6	Requests for additional information – Regulatory requirements
R7	Requests for additional information – Confirm care is consistent with Health Plan policy coverage
R8	Requests for additional information – Confirm care is consistent with health plan coverage exceptions
R9	Requests for additional information – Determination of medical necessity
R10	Requests for additional information – Support a filed grievance or appeal
R11	Requests for additional information – Pre-payment review of claims
R12	Requests for additional information – Clarification or justification of use for specified procedure code
R13	Requests for additional information – Original documents submitted are not readable. Used only for subsequent request(s).
R14	Requests for additional information – Original documents received are not what was requested. Used only for subsequent request(s).
R15	Requests for additional information – Workers Compensation coverage determination.

R16	Requests for additional information – Eligibility determination
RQ	General Questions (Yes/No Responses)-Questions that may be answered by a simple 'yes' or 'no'.
E0	Response not possible - error on submitted request data
E1	Response not possible - System Status
E2	Information Holder is not responding; resubmit at a later time.
E3	Correction required - relational fields in error.
E4	Trading partner agreement specific requirement not met: Data correction required. (Note: A status code identifying the type of information requested must be sent)
D0	Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.