

Common Claim Rejections and how to correct them

Last modified on 04/27/2026 3:45 pm EDT

Insurance claim rejections can occur for various reasons, often related to errors or mismatches in the submitted information. Below, we outline the most common reasons for claim rejections and provide step-by-step guidance on how to resolve them.

Common Reasons for Claim Rejections

1. Demographic Mismatches

A frequent cause of claim rejections is a mismatch between the patient's demographic information on the claim and the payer's records. For example, if the patient's name does not exactly match the payer's records, the claim may be rejected.

1. Verify the patient's legal name exactly as it appears with the payer (e.g., on the member ID or payer portal).
2. Update the patient's demographics in DrChrono to match the payer's records, including first name, middle initial (if applicable), last name, and suffix.
3. Regenerate and resubmit the claim after saving the corrected demographics.

2. Data Entry Errors

Errors in entering information, such as placing the Insurance ID in the wrong field, can lead to claim rejections. For instance, entering the Insurance ID in the "Insurance Group Name" field instead of the "Insurance ID Number" field can trigger a rejection.

1. Open the patient's Demographics and navigate to the Insurances tab.
2. Ensure the Insurance ID is entered in the "Insurance ID Number" field and not in the "Insurance Group Name" field.
3. Save the updated Demographics.

4. Resubmit the claim for processing.

3. Eligibility Issues

Claims may be rejected if the payer cannot find the patient in their system due to invalid or missing subscriber/insured information. This often occurs when the patient's name or other details do not match the insurance card.

1. Verify the subscriber ID and all demographic details.
2. Ensure the patient's name (including middle name/initial) exactly matches the name on the insurance card.
3. Update the demographics accordingly in DrChrono.
4. Re-run eligibility and resubmit the claim.

4. Future-Dated Adjudication/Payment Dates

Claims can also be rejected if the adjudication or payment date entered is set in the future, which is not allowed.

1. Verify that the claim's adjudication/payment date and service dates are not set in the future.
2. Correct the dates so they are on or before today's date.
3. If the claim was sent as a secondary, ensure the adjudication date from the primary payer is accurate and not in the future.
4. Resubmit the claim after updating the dates.

5. "2300 Invalid Character in NTE for Payer."

This error occurs when the EDI Billing Note (Box 19/NTE segment) contains invalid or special characters. To resolve this:

1. Open the appointment in DrChrono.
2. Navigate to the **Billing** section.
3. Locate the EDI Billing Note (Box 19/NTE segment).
4. Remove any special characters (e.g., #, ,) and ensure the note is within the allowed character limit.

5. Save the claim and resubmit it.

This ensures the claim passes scrubbing and is successfully submitted.

6. Invalid Character in Patient's Insurance Subscriber ID

If a claim is rejected due to an invalid character in the patient's insurance subscriber ID (e.g., NM1*IL line error), follow these steps:

1. Open the patient's chart and go to **Demographics** → **Insurance** tab.
2. Delete the entire Subscriber ID field to fully clear it.
3. Manually retype the correct Subscriber ID using your keyboard (avoid copy-pasting to prevent hidden or invalid characters).
4. Save the updated demographics.
5. Go to **Billing** → **Live Claims Feed** and resubmit the claim.

This process ensures the Subscriber ID is correctly formatted and accepted by the payer.

7. Invalid Subscriber ID or Ineligible Service

If a claim is rejected for an invalid subscriber ID or ineligible service, but you have already confirmed the patient's eligibility with the payer:

1. **Verify Insurance Details:** Check the patient's insurance information using their current insurance card. Update the subscriber ID and plan details in the system if necessary.
2. **Confirm Coverage:** Contact the payer to confirm coverage for the specific services billed (not just general eligibility). Record the call details, including the call reference number, representative's name, and the phone number dialed.
3. **Resubmit the Claim:** After confirming coverage, make any necessary corrections and resubmit the claim.

8. Wrong Payer ID or Route

Claims may be denied if the wrong payer ID or route is used. To resolve this:

1. **Confirm the Correct Payer ID:** Contact the payer directly to verify the correct payer ID. Ask whether claims should be sent to the payer or a third-party administrator (TPA).
2. **Document the Details:** Record the representative's name, call/reference ID, and the phone number used during the call.
3. **Update and Resubmit:** Use the confirmed payer ID for future submissions to avoid further denials.

9. Member ID Not Found

A rejection with the message "Member ID is not found" often indicates the claim was sent to the wrong payer ID, not that the member lacks coverage. For example, with BCBS plans, claims must be submitted to the specific BCBS payer that matches the routing rules for your state.

1. **Identify the Correct Payer:** Ensure the claim is sent to the appropriate BCBS entity for your state.
2. **Resubmit the Claim:** Correct the payer selection and resubmit the claim.

10. Provider Eligibility Issues

If a claim is rejected with the message "Provider was not eligible with X payer on the date of service," follow these steps:

1. **Verify Enrollment Status:** Check the provider's enrollment or credentialing status for the specific date of service (DOS).
2. **Update Credentialing:** If the provider was not active for that DOS, update their credentialing with the payer or bill under a properly enrolled provider, as per your compliance policies.
3. **Correct Data Errors:** If the provider was active, ensure there are no data errors, such as incorrect DOS, NPI/Taxonomy mismatches, or billing vs. rendering provider discrepancies.
4. **Contact the Payer:** Since this is a payer-level rejection, contact the payer's EDI department to confirm eligibility/enrollment status and obtain any required corrections before resubmitting.

11. Missing Subscriber Information Error

This error occurs when the subscriber details in the patient's insurance section are incomplete or incorrect.

1. **If the subscriber is the same as the patient:** - Open the patient's Insurance section. - Check the box labeled "Insured person is the same person as the Patient." - Save and resubmit the claim.
2. **If the subscriber is different from the patient:** - Open the patient's Insurance section. - Leave the checkbox unchecked and complete the Subscriber Information fields (e.g., subscriber's name, date of birth, patient relationship). - Save and resubmit the claim.

12. Missing Information" Error Due to Problematic Transactions

This error can arise from discrepancies in transactions, such as adjustments that make the billed amount and insurance balance inconsistent.

If a specific transaction is causing validation issues, follow these steps:

1. Identify the highlighted or incorrect transaction causing the error.
2. Delete the problematic transaction.
3. Verify and save the claim.
4. Resubmit the claim to the correct primary insurance.

This process clears discrepancies, such as adjustments that make the billed amount and insurance balance inconsistent, allowing the claim to be rebilled successfully.

Understanding Payer Front-End Rejections

Payer front-end rejections occur at the payer's system level and are not visible in DrChrono's claims department. To address these rejections:

- Contact the payer's EDI or front-end rejection team directly for details and resolution.
- Note that DrChrono can assist with clearinghouse rejections, but does not have access to payer-level rejection details.

This distinction helps you identify the appropriate party to resolve specific rejection types.

General Tips for Claim Submission

- Always review claims for special characters or formatting errors before submission.

- Ensure all required fields, such as the EDI Billing Note and Subscriber ID, are correctly filled and formatted.
 - For payer-specific issues, maintain contact information for the payer's EDI team to expedite resolution.
 - Always double-check patient demographics (name, date of birth, member ID) against the payer's records before submitting a claim.
 - Ensure all information is entered in the correct fields within the DrChrono system.
 - Regularly review and update your processes to align with payer requirements.
-