

Stop claim rejections before you hit send

Six habits for clean claim submission, plus a response plan when a claim is rejected. Check each habit and name the team member who owns it.

Who is covered?

Subscriber / policyholder

Who provided?

Provider identifiers / status

Who pays?

Payer ID / EDI enrollment

☐ 1. Verify eligibility for every visit. Owner

WHO IS COVERED?

- ☐ Check coverage for the date of service; confirm the subscriber and the patient's relationship.
- ☐ Resolve mismatches against the payer's response and retain the verification result. Eligibility is not a guarantee of payment.

☐ 2. Verify the card; keep both sides readable. Owner

WHO IS COVERED? / WHO PAYS?

- ☐ Confirm insurance information each visit. Rescan when it changes, is unreadable, or your organization's policy requires it.
- ☐ Resolve card-versus-payer discrepancies. Verify the claims payer ID against the current clearinghouse payer list.

☐ 3. Keep the provider file current. Owner

WHO PROVIDED? [1, 4]

- ☐ Verify NPIs in NPES and match payer records. An NPI lookup does not prove payer enrollment.
- ☐ Add ordering/referring details when required. For applicable Medicare services, verify name, NPI and eligible approved/opt-out status.
- ☐ Confirm payer enrollment or network requirements for the service and date; escalate gaps before resubmitting.

☐ 4. Maintain payer IDs and an enrollment tracker. Owner

WHO PAYS? [5]

- ☐ Use the claims routing ID for the correct payer and plan; do not assume an eligibility ID is the claims ID.
- ☐ Check whether EDI enrollment is required for this payer, claim type and clearinghouse. Obtain approval when required; recheck before switching routes.

☐ 5. Use edits that catch known errors. Owner

ALL THREE

- ☐ Validate required and conditional fields; do not require a referring NPI on services that do not need one.
- ☐ Review repeat causes, test the proposed edit and assign an owner. Use hard stops only where appropriate.

☐ 6. Work rejection reports every day. Owner

ALL THREE [1-3, 6]

- ☐ Review the 999 for accepted, partially accepted or rejected transactions; then check claim-level acknowledgments.
- ☐ Follow both clearinghouse and payer responses. Correct and resubmit promptly when information and approvals are ready; track unresolved items and filing deadlines.

Close the loop: A sent claim is not proof of payer acceptance. Confirm the next acknowledgment after resubmission and keep the response history.

When a rejection comes back

“A rejection is not a no. It is a not yet - and the clock is still running.”

Rejection

Fails an intake/validation check before adjudication. Typically shown on a 999, 277CA or clearinghouse worklist. Correct the error and follow the payer's resubmission rules; do not assume a corrected-claim indicator is required. [1, 2]

Denial

A claim or service is denied during adjudication. The 835 ERA explains the decision. Review the reason and the payer's correction, reconsideration or appeal process and deadlines. An ERA also reports paid claims. [1, 2]

Protect timely filing: Do not assume rejection or resubmission restarts the deadline or proves timely receipt. Keep acknowledgment records and check the payer's filing requirements. [6]

Fix the cause, not just the claim

1 | Who is covered?

Wrong ID, name/DOB, subscriber or relationship.

Fix: Verify eligibility; match the payer record; correct the registration record and the claim; resubmit.

2 | Who provided?

Invalid/mismatched NPI, missing required provider, or enrollment issue.

Fix: Verify NPPES and payer records; add required provider details; resolve enrollment with the responsible team. [4]

3 | Who pays?

Wrong payer route or missing required EDI enrollment.

Fix: Verify the claims ID and current payer list. Complete required enrollment and wait for approval; monitor filing deadlines. [5, 6]

Read the 277CA category and its detailed status together. [3]

A1: received; acceptance not confirmed. **A2:** accepted into adjudication, not a payment approval. **A3:** unprocessable. **A6:** missing information. **A7:** invalid information. Rejections require reason-specific follow-up.

Stop it from coming back | Emphanex method

1. Identify the owner

Group by cause and assign the team that creates or maintains the data.

2. Provide education

Use a de-identified rejected claim for a five-minute lesson.

3. Give tools

Provide a checklist, job aid or validated system edit.

4. Check comprehension

Ask three questions, audit the next 20 claims, and remeasure in 30 days.

Track consistently: Define unique claims, the reporting period and rejection stage. Follow rejection rate, repeat reasons and days to resubmit. Avoid counting the same rejected claim twice.

Fix it once. Fix it at the source.

I'll see you on the path.

Sources | Accessed October 28, 2026 | Click a title to open

1. CMS: Electronic Health Care Claims (2026)

3. X12: Claim Status Category Codes (2026)

5. Stedi: Transaction enrollment (accessed 2026)

2. CMS: Claims Processing Manual, Ch. 24 (2025)

4. CMS: Ordering & Certifying (2026)

6. Noridian: Timely Filing, JF Part B (2025)

The four-step loop and suggested review intervals are Emphanex practice methods, not payer standards. This checklist supports rejection prevention; it does not replace coverage, coding or payer-specific claim requirements.

Educational resource. Follow current payer requirements and your organization's policies.

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