# How to fix a claim rejected stating "RELATED CAUSES CODE: REQUIRED; MUST INDICATE ACCIDENT FOR PAYER. "

07/24/2024 5:10 pm EDT

If the patient's services are the result of an accident, the payer will want that information disclosed on the claim. The directions below will show you how to add the information so the claim can be resubmitted and processed.

- Hover over the **Billing** and select Live Claims Feed.
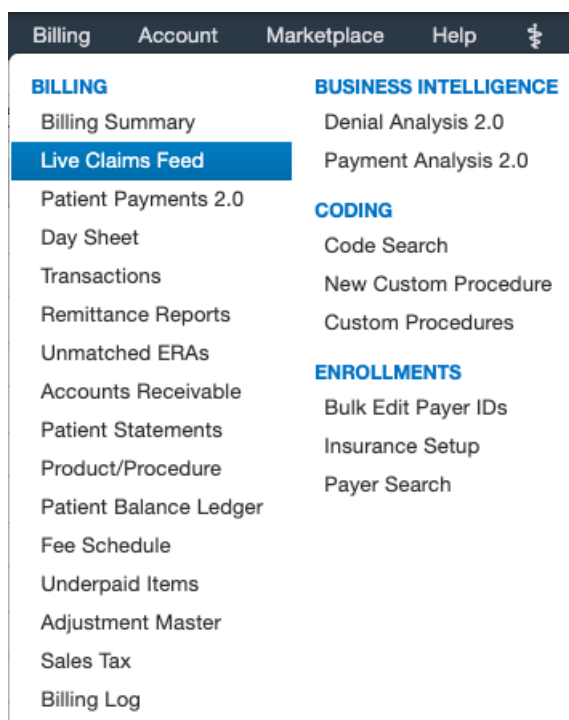
- Search for the patient appointment by the Patient name or Chart ID

- Choose the patient > click on the Date of Service

Live Claims Feed

Select All Offices | Select None | Gospel Room All ▾ | Jones Rd All ▾ | Surgery Room All ▾

Claim St **0** **844** **670** All ▾ | Billing St: All ▾ | Appt Profiles: All ▾ | TFL Warning ☐

Patient | Payer Name | Payer ID | drc claim # | 07/06/2015 — 07/06/2016 | Clinical Note

Open window in new tab ☐ | Check All | Clear | **Update Filter**

Batch Status Change ▾ | 🖨 Export to File ▾ | 🖹 Custom Export | Display ▾ | + Schedule | ⚙ Internal ▾ | 1 - 100 OF 1,514 →

	RCM	Info	Claim ID	Patient	Date of Service	Office	Billed	Allowed	Adjmt	Ins 1 Paid	Ins 2 Paid	Pt Paid	Ins Bal	Pt Bal	Claim Bal	Exp Reimbr	Ins 1
					Totals:		$805,808.96	$618,319.28	$187,489.68	$378,057.29	$0.00	$15,636.01	$153,506.89	$71,119.09	$224,625.98	$23,360.00	
☐	↪		32425064		7/06/2016 03:00PM	Surgery Room	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	united healthcare
☐	↪	S	32423212		7/06/2016 10:15AM	Gospel Room	$80.60	$80.60	$0.00	$0.00	$0.00	$0.00	$80.60	$0.00	$80.60	$0.00	Cigna
☐	↪		32425062		7/06/2016 10:00AM	Surgery Room	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	UnitedHealthcare
☐	↪	S	32342178		7/05/2016 03:15PM	Gospel Room	$266.92	$266.92	$0.00	$0.00	$0.00	$0.00	$266.92	$0.00	$266.92	$0.00	UMR (formerly Harrington Benefit Services - Westerville)
☐	↪		32343392		7/05/2016 03:00PM	Surgery Room	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	united healthcare

- In the Billing Detail screen, in the **HCFA Box 10 - Is patient's condition related to: field,** select **Yes** from the dropdown next to the appropriate type of accident; employment, auto accident, other accident (red box).

- You can enter additional information regarding the accident under the **EDI Billing Note** section (blue arrow). If you click in the box to the right of the title, a space will open where you can enter additional information that will populate in box 19 on the HCFA 1500 form.

Auto Accident Claims

When you are billing the claims out to the Auto accident insurance, update the insurance information in the Demographics > Insurances > Auto Accident section. This will give you the option to enter all of the applicable information and have that information populate in the appropriate place on the claim form.

After entering the information under Auto Accident, ensure that the payment profile under the appointment is listing Auto Accident for any claims that need to go to the auto payer. The system will know, based on the payment profile you select, to bill to the payer listed under Auto Accident, instead of Primary Ins.

Workers' Comp Claims

When you are billing the claims out to a Workers' Comp insurance, update the insurance information in the Demographics > Workers' Comp section. This will give you the option to enter all of the applicable information and have that information populate in the appropriate place on the claim form.

After entering the information under Worker's Comp, ensure that the payment profile under the appointment is listing Worker's Comp for any claims that need to go to the work comp payer. The system will know, based on the payment profile you select, to bill to the payer listed under Worker's Comp, instead of Primary Ins.

Important   Demographics   **Insurances**   Authorizations   Smoking Status   Balance

✔ **Sufficient patient demographics to bill insurance.**

Primary Ins   Secondary Ins   Tertiary Ins   Auto Accident   **Worker's Comp**   Durable Med Eqpt

Worker's Compensation   Patient Insurance History

Insurance Provider	
Insurance Payer ID	
Insurance Group Name	
Insurance Group Number	
Insurance Payer Address	
Insurance Payer Zip	
Insurance Payer City	
Insurance Payer State	—Select a State—
Date of Accident	
Insurance W.C.B. #	
Insurance W.C.B. Rating Code	
Insurance Carrier Code	
Insurance Case #	
State of Occurrence	—Select a State—
Property & Casualty Agency Claim #	*only for property & casualty claims
Workers comp notes	

Save Demographics