E000501	Location is not registered for eDental.	Contact our Dental Helpdesk, so we can check your practice status. You must be set up in our system in advance, in order to transmit claims via eDental.
E000502	Incorrect PMS and version have been supplied.	The current version of your supplier's software must be accredited by us, to allow you to submit electronically. Contact your supplier to confirm that the software version installed at the practice is the current version and is accredited.
E000503	Check the list number as it is invalid.	The list number you have entered is incorrect; there is no dentist at your location with this list number.
E000504	No location found for list number.	Make sure the list number has been entered correctly, check it is the list number provided by the NHS Board. If it is found to be correct, contact our Dental Helpdesk.
E000505	The list number is not marked as being eDental enabled, but the claim was received via eDental.	Contact our Dental Helpdesk, so we can check the list number status. This must be set up in our system in advance, in order to transmit claims via eDental.
E000506	The commitment list number is for commitment payments only. You cannot claim for treatment using this list number.	You have tried to submit a claim using a commitment list number; this list number type cannot be used to submit claims. Resubmit the claim using the correct list number.
E000507	No claims can be made against the list number. Check the correct list number has been entered.	You have tried to submit a claim using either an incorrect list number or a type of list number that cannot be used to submit claims. Resubmit the claim using the correct list number.
E000508	Check the Personal Identification Number (PIN), as the PIN supplied is invalid.	The PIN was issued to the individual dentist by NHSmail. If you cannot locate the email, contact our Dental Helpdesk.

E000509	The claim reference number has already been used for this list number and a case is either being processed or has already been paid.	You cannot re-use a reference number that has already been submitted. Confirm you have not previously submitted the claim. If you have not previously submitted the claim, contact our Dental Helpdesk.
E000510	The claim has been received previously with a higher submission count.	If you use a practice management system (PMS), get in touch with your supplier as they will need to make sure the submission count for this claim is not lower than a previous submission. If you are using the web form, contact our Dental Helpdesk.
E000511	A previous valid submission for the claim is being progressed by the payment system.	An amended claim cannot be submitted if we have already processed it through to our payment system. You should follow the claim adjustment process once payment has been made and complete a Dental 283 form, if required.
E000601	A patient details response code must be supplied if the Community Health Index (CHI) number is not specified.	You must carry out a patient details check if you have not included a CHI number in your submission.
E000602	The patient details response code is not valid for this list number.	The patient details check has been carried out using a different list number to the list number used to submit the claim for payment. Carry out a new patient details check, using the list number of the dentist who is making the payment claim.
E000603	The patient details response code has been used for a previous claim reference.	Carry out a new patient details check, using the list number of the dentist who is making the payment claim.
E000604	Previous case id must have been claimed by a different list number at the same practice.	The case ID entered in the field for the previous/original claim must relate to a claim for the same patient and the list number for a dentist at the same practice.
E000605	The patient details on the previous case id do not match the claim being submitted.	The patient details on the current claim must be the same as on the previous case ID. Check the previous case ID is correct. Patient details can be amended by submitting a patient detail amendment form, Dental 287, after the claim has been submitted.
E000606	The part number appears to be invalid. It must be +1 from the previous case id and all previous parts must form a sequence starting at 1.	Confirm you have submitted the previous part numbers of this continuation case in the correct order. There must be at least 1 day between submission of claims for different part numbers.
E000607	Check the patient's surname; ensuring only alphabetic characters are used.	The patient’s surname must be made up of only alphabetic characters, a hyphen (-) or spaces.

E000608	Patient surname must not begin with a hyphen.	Patient surname must be alphabetic (can also contain a hyphen or space), but must not begin or end with either a hyphen or a space.
E000609	Check the patient's forename; ensuring only alphabetic characters are used.	The patient’s forename must be made up of only alphabetic characters, a hyphen (-) or spaces.
E000610	Patient forename must not begin with a hyphen.	Patient’s forename must be alphabetic (can also contain a hyphen or space), but must not begin or end with either a hyphen or a space.
E000611	Check the patient's previous surname ensuring only alphabetic characters are used.	The patient’s previous surname must be made up of only alphabetic characters, a hyphen (-) or spaces.
E000612	Patient previous surname must not begin with a hyphen.	Patient’s previous surname must be alphabetic (can also contain a hyphen or space), but must not begin or end with either a hyphen or a space.
E000613	The patient's Community Health Index (CHI) number is invalid.	The format of the CHI number must be ten digits, starting with 0, 1, 2, or 3.
E000614	Check the patient’s Community Health Index (CHI) number as the first 6 digits must match the patient’s date of birth.	The first 6 characters of the CHI number must match the patient’s date of birth, in ddmmyy format.
E000615	The ninth digit of the Community Health Index (CHI) number has to be odd for males and even for females.	The ninth character of the CHI number must be an odd number if the patient’s sex is M and an even number if the sex is F.
E000616	Check the Community Health Index (CHI) number as the check digit is incorrect.	If using a CHI number held within your practice management system (PMS), it may be incorrect. Remove it and undertake a new patient details check.
E000617	Check if patient's date of birth has been entered correctly.	The patient’s age on the acceptance date must be less than the maximum allowable age. The maximum allowable age limit in our systems for a patient is currently set to 110.
E000618	The patient’s sex must be entered; “M” for Male or “F” for Female.	The patient’s sex must be entered; “M” for Male or “F” for Female.

E000619	At least one line of the patient's address must be supplied.	At least one line of the patient's address must be supplied.
E000620	You have claimed one or more treatment codes that are restricted to under 15 year olds and the patient is 15 or over.	The item claimed is only available for patients aged under 15. Check the patient's date of birth and the code(s) being claimed.
E000622	If fee codes and amount claimed have been supplied, it is necessary to enter the acceptance date, completion date and approval date (if applicable).	The Date of Acceptance and Date of Completion must be entered if treatment details have been included on the claim. If the claim requires prior approval, you must include the approval date. If you do not know where to enter this on your system, contact your supplier.
E000623	Claim dates are not in the correct sequence.	The various claim dates (if supplied) must be in ascending order, as follows: Patient's date of birth; acceptance date; approval date; completion date; current date.
E000624	The date of Registration/Acceptance for treatment does not fall within a valid Statement of Dental Remuneration (SDR).	Confirm the acceptance date, as it appears to be invalid.
E000625	The completion date does not fall within a valid Statement of Dental Remuneration (SDR).	Confirm the completion date, as it appears to be invalid.
E000626	Your claim was not received within 3 months of the completion date.	Claims cannot be submitted more than 3 month after the completion date.
E000627	The acceptance date must be on or after the implementation date of the form type.	Confirm the acceptance date is valid.
E000628	The approval date must be after or equal to the acceptance date. Note: the approval date must be the approval date provided by Practitioner Services.	The Date of Approval must be on or after the Acceptance Date and must match the approval date held in our records.

E000630	At least one treatment must be included on this claim.	Treatment must be included on this claim, as only claims for children can be accepted without treatment.
E000631	An adult registration only claim is not allowed.	Treatment must be included on this claim, as only claims for children can be accepted without treatment.
E000632	This List number cannot claim a PDS Non-GDS Claim.	The list number used for submission is not recognised as operating under the Public Dental Service (PDS). Make sure the list number used is correct.
E000635	Referral payments have been claimed but claim type is not "referred patient".	If claiming a referral fee, the patient registration status must be "I wish to be treated by this dentist as a referred patient".
E000637	You have supplied comments for 'No Radiographs available' but have specified that radiographs are available.	You have indicated radiographs are available, yet have entered remarks into the “No radiographs available” box. Amend as appropriate.
E000638	Dentist's declaration has not been entered.	Make sure the dentist’s declaration has been completed.
E000639	You have specified that the patient refused treatment but not supplied any observations.	You have indicated the patient has refused treatment, details must be provided in observations.
E000640	You are claiming a patient failed to return fee, but not selected the patient failed to return box.	As you are claiming a fee for incomplete treatment for a patient that failed to return (PFTR), you must also indicate that the claim is PFTR.
E000641	The patient's declaration on completion section is incomplete or missing.	The patient must complete their declaration by signing a PR form or digital equivalent using an eSignature. You must indicate this has been obtained.

E000642	A representative name must be supplied if the patient's representative signed for treatment.	If a patient's representative signature has been obtained, the full name of the representative must also be recorded.
E000643	Patient's signature date is missing.	The date the patient completed their declaration, either on a PR form or digital equivalent using an eSignature, must be entered.
E000644	The patient's signature is missing.	The patient must complete their declaration by signing a PR form or digital equivalent using an eSignature. You must indicate this has been obtained.
E000645	The patient's contribution to the cost of treatment must be less than the total amount claimed. Check both amounts entered.	The patient's contribution to the cost of treatment must be less than the total amount claimed. Check both amounts entered.
E000646	A treatment cost total has been entered in the amount claimed field, yet no treatment codes have been supplied. The coded amount and the amount claimed must be equal.	If the amount claimed value should be greater than £0, make sure item of service codes are entered, otherwise adjust the amount claimed value.
E000647	Treatment codes are entered, but there is no total amount entered. The coded amount and the amount claimed must be equal.	The total amount entered differs from the total expected for the specified treatment codes on the claim. Review and amend as appropriate.
E000648	Patient charge cannot exceed the statutory amount.	The patient charge must not exceed the maximum statutory amount specified in the Statement of Dental Remuneration (SDR), relevant to the claim's acceptance date.
E000649	Patient charge across all continuation parts cannot exceed the statutory amount.	The combined patient charge across all parts of a continuation case must not exceed the maximum statutory amount specified in the SDR, relevant to the claim's acceptance date.
E000650	Only one Department of Social Security (DSS) remission or exemption can be entered.	Only one remission or exemption can be entered.

E000651	Check the patient's date of birth and the exemption claimed. The patient must be 18 years of age at the acceptance date to claim exemption as a full time student.	Check the patient's date of birth, acceptance date and the exemption claimed. The patient must be 18 years of age at the acceptance date to claim exemption as a full time student.
E000653	The exemption category 'under 18 years of age' has been supplied, but the patient's age at the acceptance date was over 18. Check the patient's date of birth, acceptance date and exemption/remission category have been supplied correctly.	Check the patient's date of birth, acceptance date and exemption/remission claimed.
E000655	The exemption has been completed as 'expecting a baby' or 'had a baby in last 12 months', but the sex of the patient has been entered as male.	Check the patient's sex and exemption/remission category.
E000657	The HC3 certificate number has not been specified.	The HC3 certificate number must be specified if the exemption code on completion is HC3.
E000659	No change in remission status has been indicated, but you have specified exemption on acceptance details.	If the remission status has changed during the course of treatment, the relevant status change box should be completed.
E000660	Only one DSS remission or exemption can be entered.	Only one Department of Social Security (DSS) remission or exemption can be entered.
E000661	Patient must be 18 as at the acceptance date to claim a 'FT Student' exemption.	Check the patient's date of birth, acceptance date and the exemption claimed.
E000663	The under 18 flag is checked but the patient's age as at the acceptance date was over 18.	Check the patient's date of birth, acceptance date and the exemption claimed.

E000665	Please check the sex of the patient, and the exemption category. The exemption has been completed as 'expecting a baby' or 'had a baby in last 12 months', but the sex of the patient has been entered as male.	Check the patient's sex and exemption/remission category.
E000667	The HC3 certificate number has not been specified.	The HC3 certificate number must be specified if the exemption code on acceptance is HC3.
E000669	Patient charge must be zero for the remission details specified.	Unless the patient has a remission of HC3 at completion then the patient charge must be £0.
E000670	Patient charge must not be zero for the remission details specified.	If a patient has a remission of HC3 on completion, the patient charge cannot be £0.
E000671	Exemption category is invalid for a PDS Non-GDS claim.	Non GDS claims must use the completion exemption code specified solely for the purpose of submitting non GDS.
E000672	Exemption category is invalid for a PDS Non-GDS claim.	Non GDS claims must use the acceptance exemption code specified solely for the purpose of submitting non GDS.
E000673	As there is a completion date entered, enter the appropriate fee code(s), for the work carried out and being claimed.	If a Date of Completion is included on the claim, at least one treatment should appear on the claim.
E000674	You cannot claim Item 35(A) treatments in respect of a patient being treated under the domiciliary care regulations.	When treating patients under enhanced domiciliary care regulations you cannot claim item 35(A).

E000675	The free replacement claim made is invalid. Repair or replacement of restoration relates to any filling, root filling, inlay, pinlay or crown, which has to be repaired or replaced to secure oral health, within 12 months of the date it was originally provided.	The item being claimed as a free replacement is not recognised as a free replacement item within the SDR.
E000676	You have specified "Free Replacement" for one or more treatments but the claim does not indicate Trauma has occurred.	External trauma is the only circumstance under which a free replacement is acceptable.
E000677	Treatment code and quantity are not valid on the date of acceptance.	The code being claimed does not exist in the Statement of Dental Remuneration (SDR) for that date of acceptance.
E000678	Adult claims including treatment for which radiographs are required must indicate either Radiographs are available or an item 2 treatment code claimed or the No radiographs comments supplied.	For patients 18 and over on the acceptance date of the claim and where the item is noted in the Statement of Dental Remuneration (SDR) as requiring radiographs, the following applies: Radiographs available must be selected OR appropriate radiographs must be claimed OR appropriate remarks by the dentist are recorded because no radiographs are available or being claimed.
E000679	Under 18 claims including treatment for which radiographs are required must indicate either Radiographs are available or an item 2 treatment code (with trauma indicated) claimed or the No radiographs comments supplied.	For patients under 18 on the acceptance date of the claim and where a Statement of Dental Remuneration (SDR) item is noted as requiring radiographs, radiographs available must be selected OR in case of external trauma being indicated, an item 2(a) treatment must be claimed.
E000680	Invalid tooth identifiers have been specified.	The tooth notation provided is invalid for the fee code specified. NOTE: Retained deciduous teeth for adults should be recorded as permanent teeth.
E000681	Provide details of the tooth notation for all tooth specific items or if you are claiming for a capitation/ continuing care code make sure the tooth notation is correct for that code. Retained deciduous teeth in adults should be coded as permanent teeth.	Ensure the tooth notation is correct for the tooth specific items specified on the claim.

E000682	The quantity claimed for the tooth specified treatment does not match the number of tooth identifiers specified.	The number of teeth specified must equal the number of treatments for the item being claimed.
E000683	Form Type cannot be GP17-1 whilst Interim Fee Codes are present on the claim.	The interim fee code specified cannot be claimed on GP17-1 form type.
E000684	An invalid Annotation code has been specified in the dental chart.	Only the following annotation indicators can be used: M - Missing tooth, Z - Tooth missing and space closed, U - Unerupted tooth, F - Filling, IN - Gold Inlay.
E000685	The specified tooth surface is invalid.	Only the following tooth surface indicators can be used, up to a maximum of 5 surfaces: M - Mesial, O - Occlusal, D - Distal, B - Buccal (back teeth) or Labial (front teeth), P - Palatal (upper), L - Lingual (lower), I - Incisal.
E000686	You cannot claim Special Needs for a patient being treated under the domiciliary care regulations.	When treating patients under enhanced domiciliary care regulations you cannot claim Special Needs.
E000687	A Tooth surface must only be used once within a dental chart record.	You cannot chart the same tooth surface more than once per tooth.
E000689	Annotation code must be F or IN if a tooth surface has been specified.	If a tooth surface is specified, the annotation indicator must relate to either a filling (F) or gold inlay (IN).
E000690	A tooth surface must be specified if Annotation code is F or IN.	If claiming a filling (F) or gold inlay (IN), the tooth surface must be specified.
E000691	Material must not be specified unless annotation code is F.	The material, A - Amalgam, R – Resin or G – Glass, can only be specified if a filling is being claimed.
E000692	Material must be specified if annotation code is F.	The material, A - Amalgam, R – Resin or G - Glass must be specified if claiming a filling.
E000693	A treatment has been specified without a matching dental record.	If treatment is detailed on the claim, charting must be provided.
E000694	A charting record has been supplied without a matching treatment record.	A charting record consists of an annotation code, surface, material and supernumerary flag (if appropriate) for an item of treatment. For the tooth specified in the error, the annotation code, surface and material detailed are not required.

E000695	BPE score is invalid.	For each section of the Basic Periodontal Examination (BPE), a score in the range 0 to 4 can be provided. You can add an asterisk (*) to a score, if furcation is present. If no score is being provided for the sextant (for example, no teeth are present) a dash or cross must be recorded (- or X).
E000696	One or more treatments require prior approval but no prior approval authorisation details have been specified.	The prior approval authorisation date must be entered on the claim.
E000697	Claim requires prior approval but no prior approval authorisation details have been specified.	The prior approval authorisation date must be entered on the claim.
E000698	One or more repair or replacement treatments claimed, but without trauma indicated.	External trauma must be indicated where a free replacement is claimed.
E000699	You have claimed a treatment that is restricted to a patient being treated under the domiciliary care regulations.	You have claimed an item that can only be claimed under the enhanced domiciliary care regulations. Additional information will be provided to indicate the item code claimed in error.
E000700	Cannot claim a 10(C) treatment if the gap between acceptance and completion is less than 1 month.	Check acceptance and completion dates entered. Refer to the Statement of Dental Remuneration (SDR) for minimum number of visits required.
E000701	Completion date must be specified of amount claimed is greater than zero.	Completion date must be entered.
E000702	Claim submitted with item 36(E) no fee is payable for item 36e in connection with any item of treatment other than items 35 (domiciliary visits and recalled attendance) and 45 (continuing care payments).	Please refer to the treatment description and proviso conditions specified in the Statement of Dental Remuneration (SDR) under item 36(E).
E000704	Item 17 treatment(s) have been claimed without a corresponding 1700 treatment also being claimed.	The additional arch fee (1700) must be claimed with treatments under item 17.
E000705	Item 18(a) to 18(f)(2) or 29(D) treatments have been claimed without a corresponding Item 2b and models available not set.	For items 18(a)-(f)(2) and 29(D) you must either indicate models are available or claim item 2b.

E000707	Acceptance date on a continuation case must be the same as the acceptance date on all previous parts.	Each claim that is part of a continuation case must have the same acceptance date.
E000708	Claim type must be "2" for all continuation parts.	The claim must be "I am registered with another dentist at this practice" for continuation cases.
E000709	Prior approval is required as the total value of treatments across all continuation parts of the claim exceed the authorisation limit.	Prior approval is required. If you already have approval for this claim, the prior approval date must be entered.
E000710	A reason for referral must be provided for a referred patient.	Where the claim type is "I wish to be treated by this dentist as a referred patient", the reason for referral must be provided.
E000711	A reason for referral must not be provided for anything other than a referred patient.	Where a reason for referral is provided, the claim type must be "I wish to be treated by this dentist as a referred patient".
E000712	The HC2 certificate number has been specified without the corresponding exemption category being selected.	If an HC2 certificate number has been supplied, the exemption/remission category selected must be HC2.
E000713	The HC2 certificate number has been specified without the corresponding exemption category being selected.	If an HC2 certificate number has been supplied, the exemption/remission category selected must be HC2.
E000714	The HC3 certificate number has been specified without the corresponding exemption category being selected.	If an HC3 certificate number has been supplied, the exemption/remission category selected must be HC3.
E000715	The HC3 certificate number has been specified without the corresponding exemption category being selected.	If an HC3 certificate number has been supplied, the exemption/remission category selected must be HC3.
E000716	The benefit recipient name has been specified without the corresponding exemption category being specified.	The benefit recipient name should only be specified when the exemption/remission category is a benefit or credit.
E000717	The benefit recipient name has been specified without the corresponding exemption category being specified.	The benefit recipient name should only be specified when the exemption/remission category is a benefit or credit.
E000718	The dental charting contains an invalid tooth code.	The dental charting contains an invalid tooth code; FDI 2-digit notation must be used.

E000719	The benefit recipient name has been specified without a corresponding date of birth or national insurance number.	If the exemption details include a benefit recipient name, either the recipient's National Insurance number or date of birth MUST be included.
E000720	The benefit recipient name has been specified without a corresponding date of birth or national insurance number.	If the exemption details include a benefit recipient name, either the recipient's National Insurance number or date of birth MUST be included.
E000721	If the GDS flag is selected then non-GDS cannot be selected. If the GDS flag is not selected then non-GDS must be selected.	You must select either GDS or non-GDS.
E000722	You have specified that the patient failed to return fee is required but not supplied any observations.	If you require an incomplete code as a patient has failed to return to complete treatment, provide details in observations.
E000723	Previous Case ID is mandatory when it is a continuation case.	The Case ID of the previous part of the continuation case must be entered.
E000724	Benefit category on acceptance cannot be the same as benefit category on completion.	If a change of circumstances has been indicated the benefit category on completion must be different to the benefit category on acceptance.
E000725	You cannot indicate a change in remission status for a patient who is under 18 on date of acceptance.	If patient is under 18 on the date of acceptance, you cannot indicate a change in remission status .
E000726	The ninth digit of the Community Health Index (CHI) number has to be odd for males and even for females.	The ninth digit of the Community Health Index (CHI) number has to be odd for males and even for females.
E000750	The prior approval reference provided does not match the latest reference provided for a prior approval request.	The prior approval reference provided on this claim is invalid. The prior approval reference must be the same as the one returned with your prior approval.
E000752	The prior approval reference supplied has been used on a previous claim.	The prior approval reference entered has alreadybeen used on a previous claim The prior approval reference for this claim must be the same as the one returned with your prior approval.

E000801	A valid Prior Approval reference number and/or Approval Date is required because one or more treatment items on the claim require prior approval. If the case was granted approval on paper, the approval date must be added to the claim. Electronic approvals require both the prior approval reference number and the approval date to be submitted on the claim.	Prior approval is required. If you already have approval for this claim, the prior approval date must be entered.
E000802	The value of treatment codes and the amount claimed are different. Verify the treatment carried out and the total claimed, as both the coded amount and amount claimed must be equal.	Check the value of treatment codes and the amount claimed as they must be equal.
E000803	Fee code has a treatment value which differs from the expected value.	Contact your supplier to check the fee value assigned to this item code.
E000804	Prior approval is required as the total value of the treatments on the claim exceeds the authorisation limit.	Prior approval is required. If you already have approval for this claim, the prior approval date must be entered.
E000851	An exact duplicate of the claim being validated must not previously have been submitted by the list number.	This claim is a duplicate of a previously submitted claim.
E000852	For a claim type 2, the patient must be registered with a different list number at the same practice on the acceptance date.	For the claim type "I am registered with another dentist at this practice ", the patient must be registered with a different list number at the same practice on the acceptance date. Carry out a patient detail check, then re-submit the claim. If the claim fails for this error again it is likely the patient is not registered with the dentist you think.
E000853	You have claimed more than the maximum number of treatments allowed within a given period for this patient.	Additional information will be provided to indicate the item code claimed in error.

E001006	The patient's sex must be entered; 'm' for Male or 'f' for Female.	The patient's sex must be entered; 'm' for Male or 'f' for Female.
E001007	The patient details request reference has already been used for this list number.	Carry out a new patient details check, using the list number of the dentist who is making the claim.
E001008	The initial search reference is not valid for this list number.	Carry out a new patient details check, using the list number of the dentist who is making the claim.
E001009	Reconciliation details are not currently available for the specified practice.	Reconciliation details can only be returned after claims have been paid in a schedule.
E001101	Where a continuation case previous approval details are entered, the continuation case part number must be greater than 1.	Continuation cases only require previous approval details on parts 2 and above.
E001102	Where a continuation case previous approval details are entered, the previous prior approval reference used to identify an earlier submission must be valid.	Ensure the prior approval reference used for a continuation case is the same reference that was supplied previously.
E001103	Observations must be provided if you have requested a review.	Observations must be provided.
E001104	The patient details response reference included in the message has not been used previously on a prior approval request or claim (MIDAS) with a different Practice Prior Approval Reference number.	The patient details response reference included must have already been used on either a prior approval request or payment for a claim that required prior approval.
E001105	Non GDS claims are not subject to prior approval. Please confirm your intention.	Prior approval is not required for the service this list number is registered for.

E001106	Where private treatment has been marked as being provided, details of the treatment must be completed.	Where some of a treatment was provided privately you must provide details.
E001107	Where the number of intra-oral (periapical) radiographs is 1 or more then the teeth covered by the radiograph should be included in the submission.	Where the claim includes an intra-oral (periapical) radiograph, you must detail the teeth covered.
E001108	Where a vitality test has been marked as being available, a vitality report must be provided.	Provide vitality report.
E001109	Sedation administered by an operator can only be selected where the treatment itself has been marked as requiring sedation.	You have indicated the operator will administer the sedation, but you have not indicated that sedation is required.
E001110	The name of the sedationist must be specified if the sedation is not being carried out by the operator.	Provide the name of the person carrying out the sedation, if not the dentist.
E001111	Item 25(a) and Item 25(b) cannot be claimed where sedation is being administered by the operator.	Item 25(a) and Item 25(b) cannot be claimed where sedation is being administered by the operator.
E001112	Confirm all dentist declarations have been positively selected.	All dentist declarations must be completed.
E001113	Baseline charting must be provided in the prior approval submission from Practice Management Systems.	Ensure a prior approval is not submitted without baseline charting.
E001114	Baseline charting must be provided in the prior approval submission from the Web form.	Ensure a prior approval is not submitted without baseline charting.
E001115	Within baseline charting, if an annotation code is supplied, it must be valid.	Ensure the annotation codes are valid.

E001116	Where the patient is over the age of 18 on the acceptance date, a full BPE score should be provided. Where the BPE is not available, remarks should be completed providing a reason.	Ensure BPE scores are provided for patients over the age of 18 as at the acceptance date. If not available, a reason must be provided.
E001117	Where no examination fee codes are being claimed, the no examination reason field must be completed.	A reason must be provided in the relevant field if no examination has taken place.
E001118	Where a medical condition has been indicated, details of the condition must be provided.	Details of the medical condition must be provided in the relevant field.
E001119	Where non cariogenic tooth wear has been identified, details must be entered and a response provided on whether the condition requires treatment.	Provide details on whether treatment is required.
E001120	Details of pertinent intra-oral features are only required where intra-oral features are indicated.	You have provided details for intra-oral features, but have not indicated that intra-oral features are present.
E001121	The patient or dentist initiated prior approval fields can only be marked and a reason included, where prior approval is no longer required.	You have completed some of the fields where prior approval is no longer required, but have not indicated that approval is no longer required.
E001123	When physical evidence has been sent and marked as such, the type of physical evidence sent must be selected.	If physical evidence has been marked as sent, detail the type of physical evidence.
E001124	Supplementary information can only be provided in one of the following circumstances: - When you have indicated that physical evidence has been sent - When you have indicated electronic attachments have been uploaded - When notes have been included If you have indicated Prior Approval is no longer required, you will be unable to add supplementary information.	Check you have completed the correct supplementary information.

E001125	The treatment proposed in a re-approval or continuation case must differ from treatment that has already been approved.	If there are no changes to the treatment plan, re-approval is not required.
E001126	The previous prior approval reference number provided in a continuation case must be for an approved or closed case relating to the same patient, and from a list number within the same practice.	Check the prior approval reference number provided.
E001127	Where the same prior approval reference has been submitted and had been previously approved, the case should be marked as a re-approval.	If you have changed the treatment plan and wish to submit a request for re-approval, you must mark the case as a re-approval.
E001128	It is not possible to submit a request for an existing case unless a request for additional information has been received or you are seeking re-approval of an approved case.	This case is not at the correct status to allow you to re-submit it, unless the treatment plan has changed and you are seeking re-approval.
E001129	A submission has been received with the same prior approval reference as a previous submission. Information has been requested on the previous submission so the case is not a re-approval. The latest submission must include supplementary information or different submission details from that supplied previously.	If you are seeking re-approval, the treatment plan must be different to the original approved plan. Otherwise, please provide the additional information requested when the case was returned to you.
E001130	Where a request is marked as requiring re-approval, the prior approval reference submitted that relates to an earlier case must have either been approved or information has been requested.	You cannot submit a further request for a previously submitted case unless we requested additional information or you are requesting re-approval for an approved case.

E001131	Treatments or charting records cannot be submitted for more than two teeth in the same position. If treatment needs to be performed on more than two teeth, submit the treatment for two and add treatment 399901 and observations to cover the additional teeth.	Treatments or charting records cannot be submitted for more than two teeth in the same position. Supernumerary teeth must always be one of the charted teeth and any 3rd tooth in the same position should have the treatment and the tooth recorded in observations.
E001200	The previous part must have been approved for a continuation or transfer case to proceed.	The previous part must have been approved for a continuation or transfer case to proceed.
E001201	A new request for approval is only required where the treatment plan has changed.	For continuation cases, re-approval is only required when the treatment plan changes.
E001202	A re-approval can only be processed if the treatment plan has changed.	Re-approval is only required when the treatment plan changes.
E001203	This case has already been approved, and further submissions will only be processed if the treatment plan is changing.	Re-approval is only required when the treatment plan changes.
E001204	A previous submission is currently being reviewed, you will need to wait until we have returned the case to you.	Please wait for the previous submission of this treatment plan to be returned to you before trying to resubmit.
E001205	If you have uploaded digital attachments or sent physical evidence, you must indicate this before re-submitting.	You must indicate on your prior approval request that you have uploaded digital attachments and/or sent physical evidence before re-submitting the request.
E001206	A subsequent submission using the same practice reference number and message type has been received for a claim which is already being (or has been) processed. This subsequent submission has been made without a request for information being received.	You must wait for the previous submission of this case to be returned to you before you can re-submit.

E001207	A subsequent submission using the same practice reference number and message type has been received for a claim which is already being (or has been) processed. This subsequent submission has been made without a request for information being received.	You must wait for the previous submission of this case to be returned to you before you can re-submit.
E001208	The Discontinued Case was authorised but the authorised details do not match those included on the final payment claim.	The authorised details for the discontinued case do not match those included on the case.
E001209	Discontinued item(s) must be authorised if they are to be included on a final payment.	Please wait for authorisation of the Discontinued Case before submitting for Final Payment.
E001210	You cannot submit a final payment or discontinued case until the interim payment you submitted has been processed.	Please wait for the interim payment to be processed before submitting any further claims for this treatment plan.
E001211	This practice reference cannot be reused by this message type.	This practice reference cannot be reused by this message type.
E001212	As this is a continuation case, the prior approval reference must relate to an approval obtained by another dentist at the practice.	The prior approval reference must relate to an approval obtained by another dentist at the practice.
E001213	Practice reference must relate to an approval obtained by another dentist at a different practice.	Practice reference must relate to an approval obtained by another dentist at a different practice.
E001214	The previous part of the case has not received its final payment yet.	Please wait for the previous part of the case to be processed before submitting any further claims for this treatment plan.
E001250	This message type does not contain the mandatory details required. Please see additional information for more details.	Please see additional information.

E001300	The Message Type must be the same as the previous submission unless this is a message type 'D' (Final Payment) and the previous submission is a 'B' (Interim Payment) or 'I' (Discontinued Fee Request), or this is an 'I' (Discontinued Fee Request) and the previous submission is a 'B' (Interim Payment).	The list number and practice reference for this case cannot be used for this message type, as it has previously been used for a different message type.
E001301	For this continuation case, the Previous Case ID stated has not processed as far as our payment system.	The previous part of the continuation case has either not been submitted, not received its final payment yet or you have provided an incorrect Previous Case ID.
E001302	The Date Appliance Fitted should be after the Acceptance date and on or before the Completion Date.	The Date Appliance Fitted should be after the Acceptance date and on or before the Completion Date.
E001303	Medical History Details should only be provided when you have indicated the patient has previous Medical History.	You have provided "Medical History Details" but have not indicated the patient has previous Medical History.
E001304	Asymmetry Details should only be provided when you have indicated the patient has Asymmetry.	You have provided "Asymmetry Details" but have not indicated the patient has Asymmetry.
E001305	No Radiograph Remarks Details should only be provided when you have indicated that radiographs are not available.	You have provided "No Radiograph Remarks Details" but have not indicated that radiographs are not available.
E001306	Additional information pertaining to Habits should only be provided when you have indicated the patient has Habits.	You have provided “Additional information pertaining to Habits” buthave not indicated the patient has Habits.
E001307	Additional information pertaining to Previous Orthodontic Treatment should only be provided when you have indicated the patient has had Previous Orthodontic Treatment.	You have provided “Additional information pertaining to Previous Orthodontic Treatment”but have not indicated the patient has had Previous Orthodontic Treatment.

E001308	Max Contact Point field must be present for all submissions with IOTN DHC Full equal to 'd'.	The max contact point must be specified if the IOTN DHC Full score is d.
E001309	When the IOTN DHC field score is equal to 3 then IOTN AC value must be present.	The Aesthetic Component of the IOTN score must be specified when the IOTN score is equal to 3.
E001310	If you have noted crowding, specify the positions of the affected teeth.	If crowding is noted on the submission, the affected teeth positions must be noted.
E001311	If you have noted spacing, specify the positions of the affected teeth.	If spacing is noted on the submission, the affected teeth positions must be noted.
E001313	If you have noted openbite, specify the positions of the affected teeth.	If openbite is noted on the submission, the affected teeth positions must be noted.
E001314	If you have noted any displacement with a value greater than zero, specify the positions of the affected teeth.	If displacement is noted on the submission, the affected teeth positions must be noted.
E001315	An invalid treatment objective has been added to the case.	Only treatment objectives from the following list are valid: 01 - Comprehensive treatment; 02 - Compromise treatment; 03 - Interceptive treatment only and 04 - Monitor further dental development or Oral Health .
E001316	If Treatment Code is 3203 or 3204, then Quad Helix must be specified.	If a simple fixed upper (3203) or lower (3204) appliance is claimed then Quad Helix must be selected.
E001317	For patients under 18 years of age, the periodontal child patient declaration must be selected. By selecting this declaration, you are declaring that you have examined the periodontal tissues, there is good oral hygiene, good periodontal condition and no evidence of early onset juvenile periodontitis.	For patients under 18 years of age, the Periodontal declaration must be selected.
E001318	When Option for No Treatment is not selected, the Treatment Proposal section Comment field must be populated.	You must populate the Treatment Proposal section Comment field when “Option for No Treatment” is not selected.
E001321	eOrtho treatment cannot be performed if all the charted teeth are deciduous.	Orthodontic treatment cannot be performed if all the charted teeth are deciduous.

E001323	The patient declaration on completion must be included unless the patient failed to complete the treatment.	The patient declaration on completion must be included unless the patient failed to complete the treatment.
E001324	When CEPH radiograph treatment is being claimed, at least one of the Cephalometric analysis fields must be supplied.	When CEPH radiograph treatment (0205) is claimed, a full analysis must be provided by populating the cephalometric analysis fields.
E001325	When Radiographs are claimed, Charting and/or at least one of the following types of charting records must be included: un-erupted, poor prognosis, supernumerary, absent/missing or observations.	When Radiographs are claimed, Charting and/or at least one of the following types of charting records must be included: un-erupted, poor prognosis, supernumerary, absent/missing or observations.
E001326	The retention fee codes claimed relate to a longer period of time than the period calculated between the acceptance and completion dates.	The length of time between the acceptance date and completion date must be equal to or greater than the period of retention being claimed.
E001327	Prior Approval Reference number or Date of Approval must be included where the Total Value of the Claim (excluding items excluded from prior approval) is greater than your personal approval limit.	Prior Approval Reference number or Date of Approval must be included on the claim.
E001328	The prior approval reference provided does not match the latest reference provided for a prior approval request.	The prior approval reference provided does not match the reference provided for a prior approval request.
E001329	The Prior Approval Reference included on this Interim Payment has previously been used on an earlier Interim Payment claim.	The Prior Approval Reference included on this Interim Payment has previously been used on an earlier Interim Payment claim.
E001330	The Interim Payment details are incomplete, please check and enter any missing information.	The Interim Payment details are incomplete, please check and enter any missing information.
E001331	On an Interim Payment, the Date Appliance Fitted must be after the Date of Acceptance. If the case required Prior Approval, the Date the Appliance Fitted must also be after the Approval Date.	The dates on an Interim Payment must be in the following ascending order: Date of Acceptance >Date of Approval>Date of Fitting.

<table>
<tr><td>E001332</td><td>The total number of appliances claimed for Interim Payment (32a1, 32a2, 32a3, 32a4) must be less than or equal to the total number of appliances claimed in the overall treatment plan.</td><td>You cannot claim an Interim Payment for more appliances than claimed on the overall treatment plan.</td></tr>
<tr><td>E001333</td><td>The Treatment Details included on this claim do not match the treatment details approved on the Prior Approval.</td><td>The Treatment Details included on this claim do not match the treatment details approved on the Prior Approval.</td></tr>
<tr><td>E001334</td><td>The number of appliances claimed for Interim Payment (32a1, 32a2, 32a3, 32a4) must correspond to treatments in the overall treatment plan.</td><td>The number of appliances claimed for Interim Payment (32a1, 32a2, 32a3, 32a4) must correspond to treatments in the overall treatment plan.</td></tr>
<tr><td>E001335</td><td>The combination of treatment code and quantity for Interim Payment should be a valid 32(f) Interim Payment code.</td><td>A valid interim payment code needs to be specified. These are currently 329109, 329110 and 329111.</td></tr>
<tr><td>E001336</td><td>For Interim Payment, the combination of appliances claimed (32a1, 32a2, 32a3, 32a4) does not match to the Interim Payment treatment code and quantity specified.</td><td>For Interim Payment, the combination of appliances claimed (32a1, 32a2, 32a3, 32a4) does not match the Interim Payment treatment code and quantity specified. See table below:
<table>
<tr><th colspan="4">Quantity</th><th>Fee Code</th></tr>
<tr><td>32a1</td><td>32a2</td><td>32a3</td><td>32a4</td><td></td></tr>
<tr><td>1</td><td>0</td><td>0</td><td>0</td><td>329109</td></tr>
<tr><td>0</td><td>1</td><td>0</td><td>0</td><td>329109</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>1</td><td>329109</td></tr>
<tr><td>0</td><td>0</td><td>1</td><td>0</td><td>329110</td></tr>
<tr><td>2</td><td>0</td><td>0</td><td>0</td><td>329110</td></tr>
<tr><td>1</td><td>1</td><td>0</td><td>0</td><td>329110</td></tr>
<tr><td>0</td><td>2</td><td>0</td><td>0</td><td>329110</td></tr>
<tr><td>1</td><td>0</td><td>1</td><td>0</td><td>329111</td></tr>
<tr><td>0</td><td>1</td><td>1</td><td>0</td><td>329111</td></tr>
<tr><td>0</td><td>0</td><td>2</td><td>0</td><td>329111</td></tr>
</table></td></tr>
<tr><td>E001337</td><td>An examination claim can only be claimed if permanent teeth are present.</td><td>If there are no permanent teeth present, an examination cannot be claimed.</td></tr>
</table>

E001338	An Item 1(a) examination must be completed on the acceptance date.	An Item 1(a) examination must have the same acceptance and completion date.
E001339	At least one treatment objective must be provided if an examination has taken place.	If an examination has taken place, at least one treatment objective must be provided.
E001340	Only one type of examination can be claimed.	Only one type of examination (1a, 1b, 1c) can be claimed.
E001341	Referrals cannot be claimed on an examination.	Referrals cannot be claimed on an examination.
E001342	X-rays and models must be claimed or you must have indicated they are available.	X-rays and models must be claimed or you must have indicated they are available.
E001343	Assessment details must be supplied if a 1B or 1C examination has taken place.	Assessment details must be supplied if a 1B or 1C examination has taken place.
E001347	Claim dates (if supplied) must be in ascending order, as follows: patient's date of birth>acceptance date>approval date>completion date>current date.	Claim dates (if supplied) must be in ascending order, as follows: patient's date of birth, acceptance date, approval date, completion date and current date.
E001348	An Interim payment has been made but the appropriate interim payment recovery code has not been included in the Final Payment claim.	An interim payment has been made for this course of treatment. Please include the appropriate interim payment recovery code on the final payment claim.
E001349	Retention cannot be claimed on a final payment claim.	Retention cannot be claimed on a final payment claim.
E001350	Items 32(a)(3) cannot normally be claimed if the active treatment lasts less than 12 months. Observations need to be included if less than 12 months.	Items 32(a)(3) cannot normally be claimed if the active treatment lasts less than 12 months. Observations need to be included if less than 12 months.
E001351	An Item 1(c) fee must be on the claim or been claimed in the last 23 months or observations must be supplied.	An Item 1(c) fee must be on the claim or been claimed in the last 23 months or observations must be supplied.
E001352	The claim does not include either a Prior Approval reference or Approval Date and no Objectives are present.	The claim does not include either a Prior Approval reference or Approval Date and no Objectives are present.

E001353	The claim does not include either a Prior Approval reference or Approval Date and no Assessment is present.	The claim does not include either a Prior Approval reference or Approval Date and no Assessment is present.
E001354	A Discontinued Fee Request must have been made if Discontinued Treatment Code(s) are being claimed.	A Discontinued Fee Request must have been made if Discontinued Treatment Code(s) are being claimed.
E001355	Discontinued treatment codes on the Final Payment claim do not match those on the authorised Discontinued Fee Request.	Discontinued treatment codes on the Final Payment claim do not match those on the authorised Discontinued Fee Request.
E001357	A date fitted must be supplied with an Item 32(a)3.	A date fitted must be supplied with an Item 32(a)3.
E001358	Observations must be specified on a discretionary item claim.	Observations must be specified on a discretionary item claim.
E001359	On a claim for Retainers, referrals cannot be claimed.	Referrals cannot be claimed on a claim for Retainers..
E001360	On a regulation 9 claim, if a patient pays a deposit but is not required to pay a contribution, then the practitioner must confirm that the deposit has been refunded.	On a regulation 9 claim, if a patient pays a deposit but is not required to pay a contribution, then the practitioner must confirm that the deposit has been refunded.
E001361	On a regulation 9 claim, the reasons an appliance no longer fits must be specified.	On a regulation 9 claim, the reasons an appliance no longer fits must be specified if the reason for replacement is "doesn't fit".
E001362	On a regulation 9 claim, if a patient is not due a contribution, the amount they are due will be zero.	On a regulation 9 claim, if a patient is not due a contribution, the amount they are due will be zero.
E001363	On a regulation 9 claim, a deposit value should not be specified if the claim indicates no deposit was paid.	On a regulation 9 claim, a deposit value should not be specified if the claim indicates no deposit was paid.
E001364	Where item 32(a)2 or 32(a)3 is part of a discontinued claim, the teeth bonded and number of visits must be specified.	Where item 32(a)2 or 32(a)3 is part of a discontinued claim, the teeth bonded and number of visits must be specified.

E001365	Where item 32(a)1 or 32(a)4 is part of a discontinued claim, the number of visits must be specified.	Where item 32(a)1 or 32(a)4 is part of a discontinued claim, the number of visits must be specified.
E001366	Where 32(a)5 is part of a discontinued claim, the period of retention and number of visits must be specified.	Where 32(a)5 is part of a discontinued claim, the period of retention and number of visits must be specified.
E001367	The treatment codes included for the discontinued items must be included in the treatment plan.	The treatment codes included for the discontinued items must be included in the treatment plan.
E001368	Prior Approval Reference number or Date of Approval must be included where the Total Value of the Claim (minus items excluded from prior approval) is greater than the approval limit. If the case was granted approval on paper, the approval date must be added to the submission. Electronic approvals require both the prior approval reference number and the approval date to be submitted.	Where the Total Value of the Claim (minus items excluded from prior approval) is greater than the approval limit, a Prior Approval Reference number and/or Date of Approval must be included.
E001370	For a discontinued claim, either patient failed to return and/or patient refused treatment must be selected.	For a discontinued claim, either patient failed to return and/or patient refused treatment must be selected.
E001371	An exact duplicate of the payment claim has been received.	An exact duplicate of the payment claim has been received.
E001372	The patient has been matched to an existing patient who does not have an active registration.	Patient must be registered either to a dentist in practice or elsewhere (if referred to a specialist).
E001373	A claim for a final payment must use the same practice reference as a previous interim payment.	A claim for a final payment must use the same practice reference number as the previous interim payment for the same course of treatment.
E001374	We have not received a previous valid prior approval request for this case.	We have not received a previous valid prior approval request for this case.
E001375	The part number appears to be invalid. It must be +1 from the previous case id and all previous parts must form a sequence starting at 1.	Continuation part number must always be submitted in sequence.
E001376	The submission count cannot be greater than 9.	The submission count cannot be greater than 9. You need to discard this claim and start a new one.

E001377	The patient's sex must be entered; 'm' for Male or 'f' for Female.	The patient's sex must be entered; 'm' for Male or 'f' for Female.
E001378	If Displacement Centric is true, then you must supply a value for left, right or forward.	If a displacement centric is indicated, a value needs to be included, for at least one: left, right or forward.
E001379	The IOTN section must be completed when a prior approval request has been made.	The IOTN section must be completed when a prior approval request has been made.