Rejection Code Decoder

User Manual

rejectioncodedecoder.com

A plain-language guide for behavioral health billing coordinators

Version 1.0 | June 2026 | For Ohio BH Practices

CONFIDENTIAL — SEO Site Central / Rejection Code Decoder

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1. Introduction

The Rejection Code Decoder (RCD) is a web-based tool designed specifically for behavioral health (BH) billing coordinators in Ohio. When an insurance payer denies or adjusts a claim, they send back a pair of codes on the Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA):

- CARC — Claim Adjustment Reason Code: explains why the payment was adjusted.
- RARC — Remittance Advice Remark Code: provides additional context or instructions.

These codes are defined by the X12 EDI standard, but the official explanations are often vague, technical, and written for systems — not for people. The Rejection Code Decoder translates them into:

- Plain-language explanations of what actually happened with the claim.
- BH-specific root cause analysis tailored to mental health and SUD billing.
- Step-by-step next actions to resolve the denial.
- Ohio payer-specific notes for each of the major Ohio BH managed care plans.

> **NOTE:** The Rejection Code Decoder does not store any patient data, claim numbers, or protected health information (PHI). It is a reference tool only.

This manual covers every feature of the application, from creating your account to reading a Denial Resolver result. If you are new to RCD, start with Section 2 (Getting Started). If you are looking for a specific feature, use the Table of Contents above.

2. Getting Started

2.1 Accessing the Application

RCD runs entirely in your web browser — there is nothing to download or install. It works on desktop computers, laptops, tablets, and smartphones.

To open the application, navigate to:

https://rejectioncodedecoder.com

> **TIP:** RCD works best in Google Chrome, Microsoft Edge, or Safari. Internet Explorer is not supported.

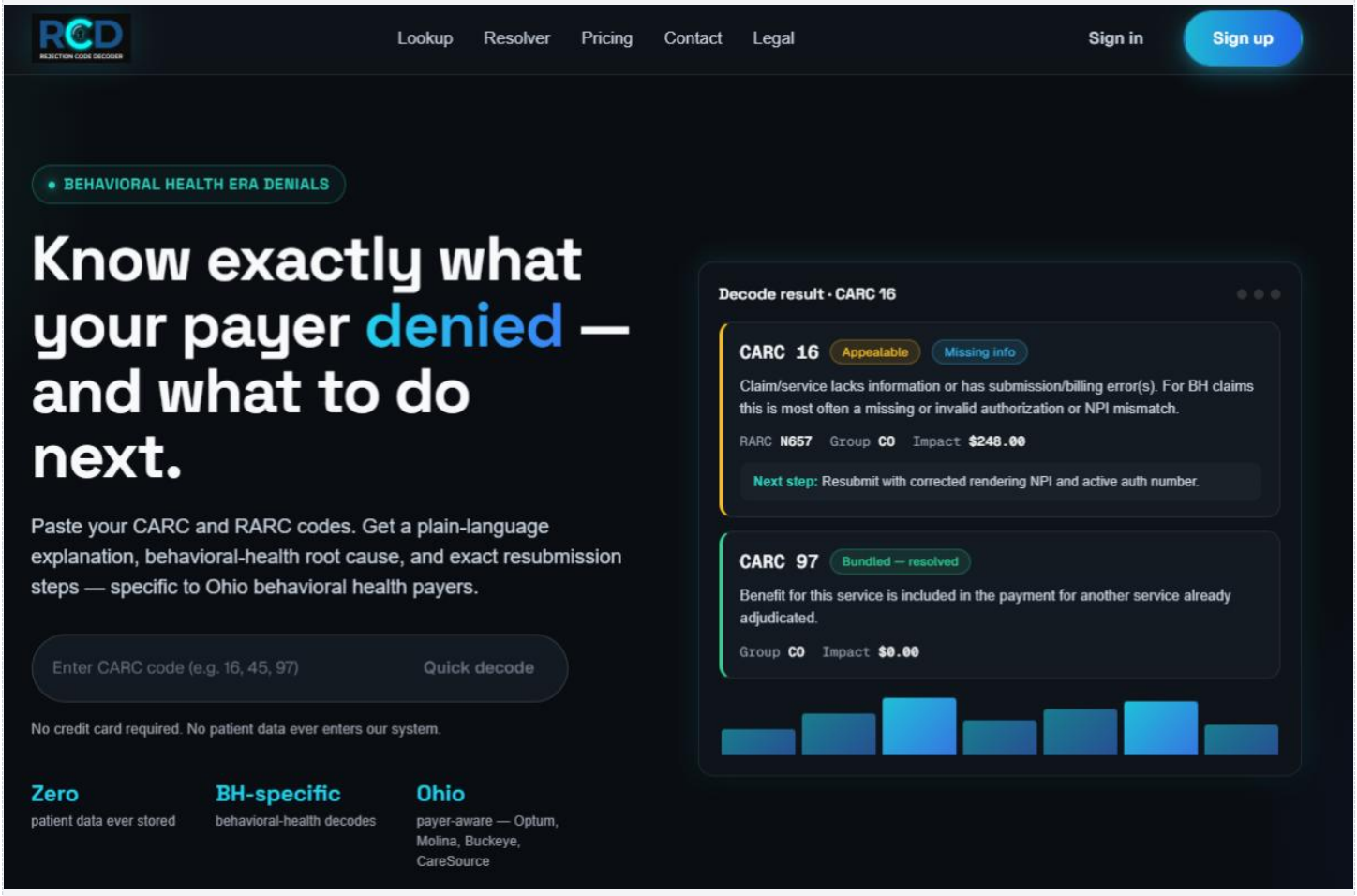

Figure: The RCD home page. Click "Try It Free" or "Sign Up" to get started.

2.2 Free Tier vs. Paid Subscription

RCD offers two access levels:

Field / Element	Description
Free Tier	Up to 5 code lookups per month. No credit card required. Create a free account to track your lookups and access history.
Paid ($79/mo)	Unlimited lookups, full Lookup History, and complete Denial Resolver access. Cancel anytime from your Account page.

Your free lookup count resets on the 1st of each month. The counter is visible in the top navigation bar when you are signed in.

TIP: Free-tier lookups work without an account — just visit /lookup and start searching. Creating a free account saves your lookup history.

2.3 Creating Your Account

Creating an account is free and takes under a minute. No credit card is required for the free tier.

1. Go to rejectioncodedecoder.com and click "Sign Up" in the top navigation bar, or visit rejectioncodedecoder.com/sign-up directly.
2. Enter your email address and create a password.
3. Click "Create Account."
4. Check your email for a verification link and click it to confirm your address.
5. You are now signed in and ready to use RCD.

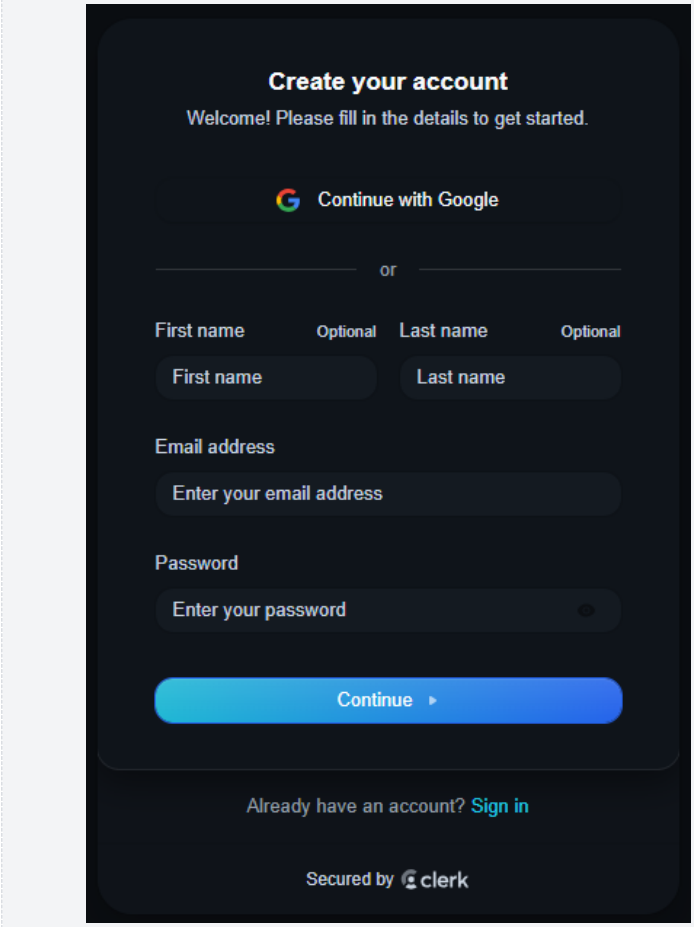

Figure: The account creation page. Enter your email and password to register.

> **NOTE:** Your account email is used only for login and billing receipts. RCD does not send marketing email.

2.4 Signing In

If you already have an account, sign in at rejectioncodedecoder.com/sign-in.

6. Click "Sign In" in the top navigation bar.
7. Enter the email address and password you registered with.
8. Click "Sign In." You will be redirected to the Lookup page.

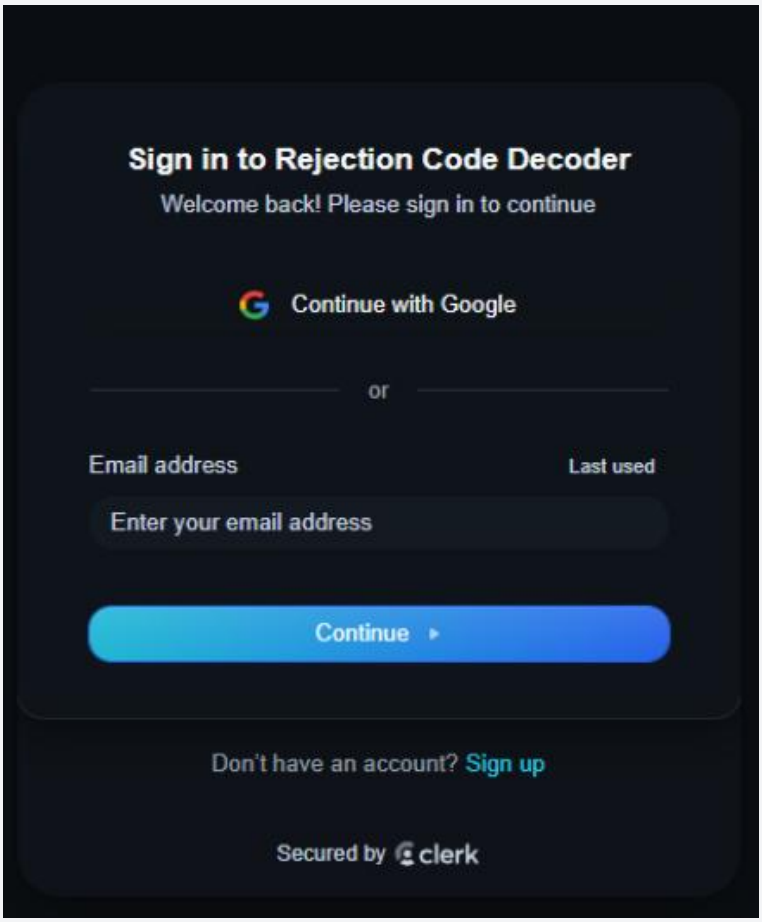

Figure: The sign-in page. Enter your email and password to access your account.

TIP: If you forget your password, click "Forgot Password?" on the sign-in page. A reset link will be emailed to you.

3. The Decoder — Looking Up a Code

3.1 Overview of the Lookup Page

The Lookup page (/lookup) is the main tool in RCD. It lets you search for a CARC code, a RARC code, or both together, and returns a plain-language explanation with BH-specific guidance.

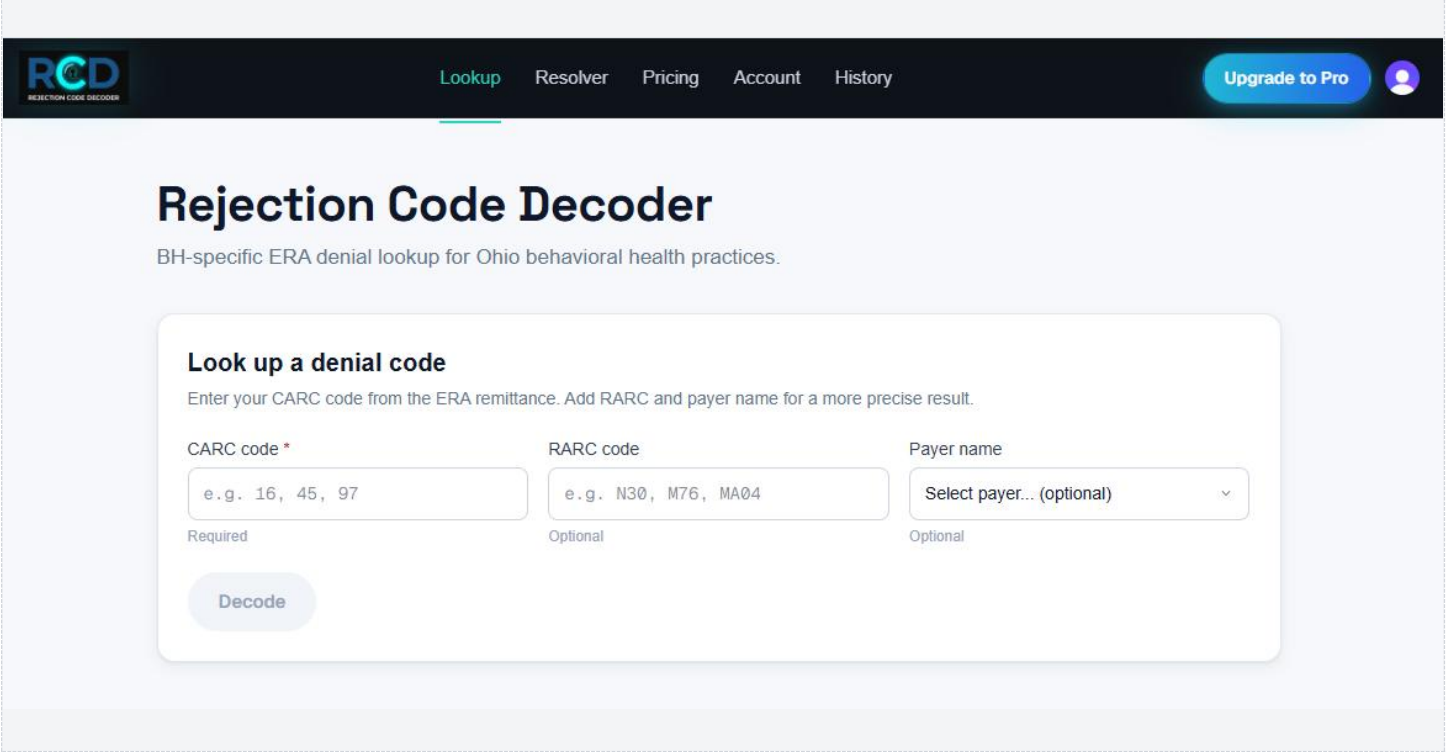

Figure: The main Lookup page. The search panel is on the left; results appear on the right.

The Lookup page has three main areas:

Field / Element	Description
Search Panel	On the left (or top on mobile). Contains the CARC dropdown, RARC dropdown, and Payer selector. This is where you enter the codes from your EOB/ERA.
Results Area	On the right (or below on mobile). Displays the decoded explanation, root cause, and next steps after you run a lookup.
Lookup Counter	Shown in the top navigation bar. Displays how many of your monthly free lookups you have used (e.g., "3/5 used"). Hidden on paid plans.

3.2 Step-by-Step: Running a Lookup

Follow these steps to look up a denial code from your EOB or ERA:

Step 1 — Enter the CARC Code

In the "CARC Code" field, type the number from your EOB. For example, if your EOB shows "PR-197," type

197

As you type, a dropdown list will appear with matching codes. Click the correct code to select it. You can also type partial numbers — for example, typing "19" will show all codes starting with 19.

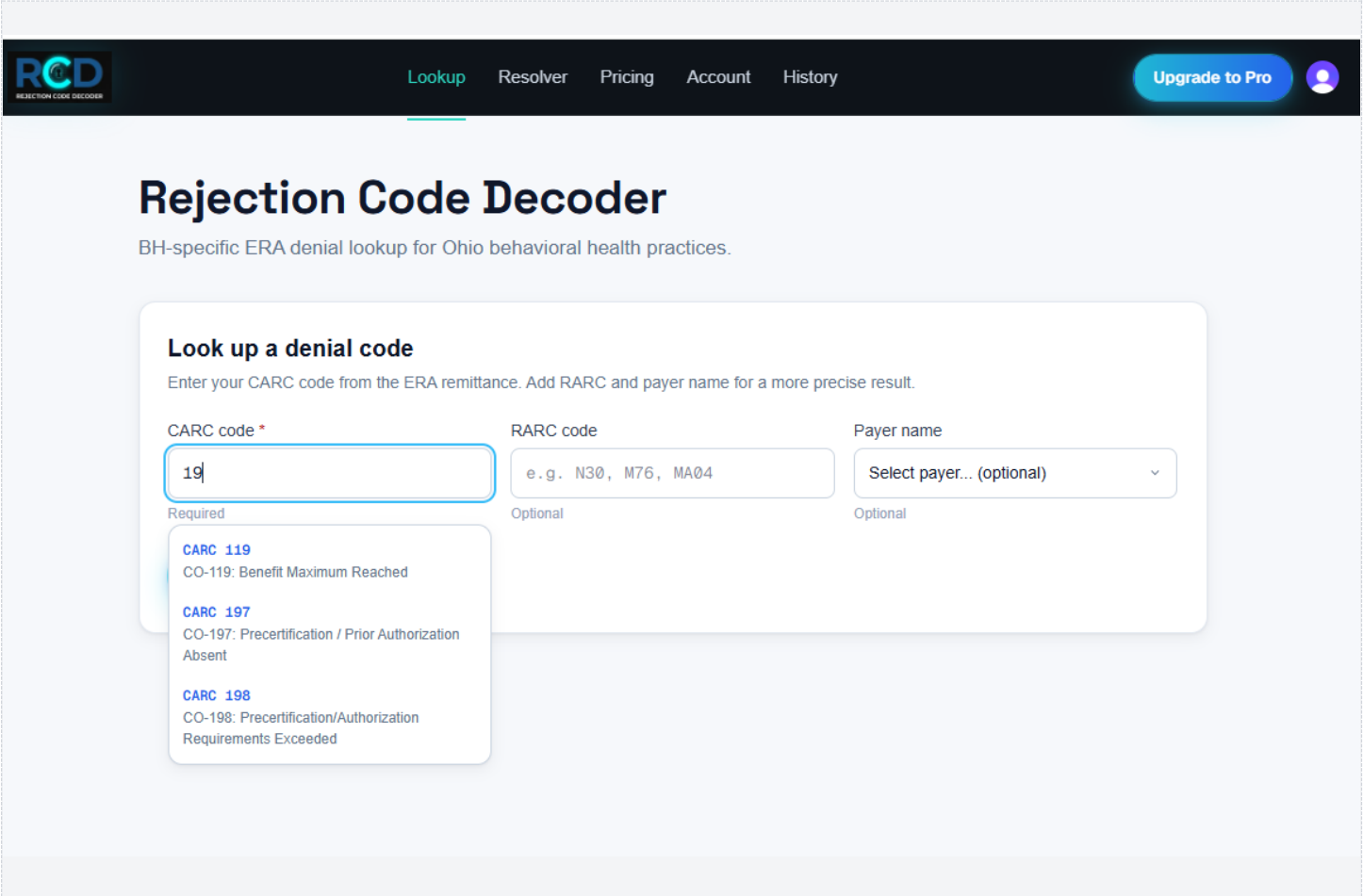

Figure: Type a CARC code number in the search field. A dropdown of matching codes appears.

NOTE: CARC stands for Claim Adjustment Reason Code. It is a number (e.g., 97, 197, 16) that appears on every EOB and ERA. You can find it labeled as "Reason Code," "Adjustment Code," or "CARC" depending on your payer.

Step 2 — Enter the RARC Code (Optional but Recommended)

In the "RARC Code" field, type the remark code from your EOB, if one is present. RARC codes begin with a letter — most commonly "N" followed by numbers (e.g., N479, N56), or "MA" (e.g., MA01, MA130).

Not every denial includes a RARC. If your EOB does not show one, leave this field blank. However, entering the RARC when available will give you a much more specific explanation.

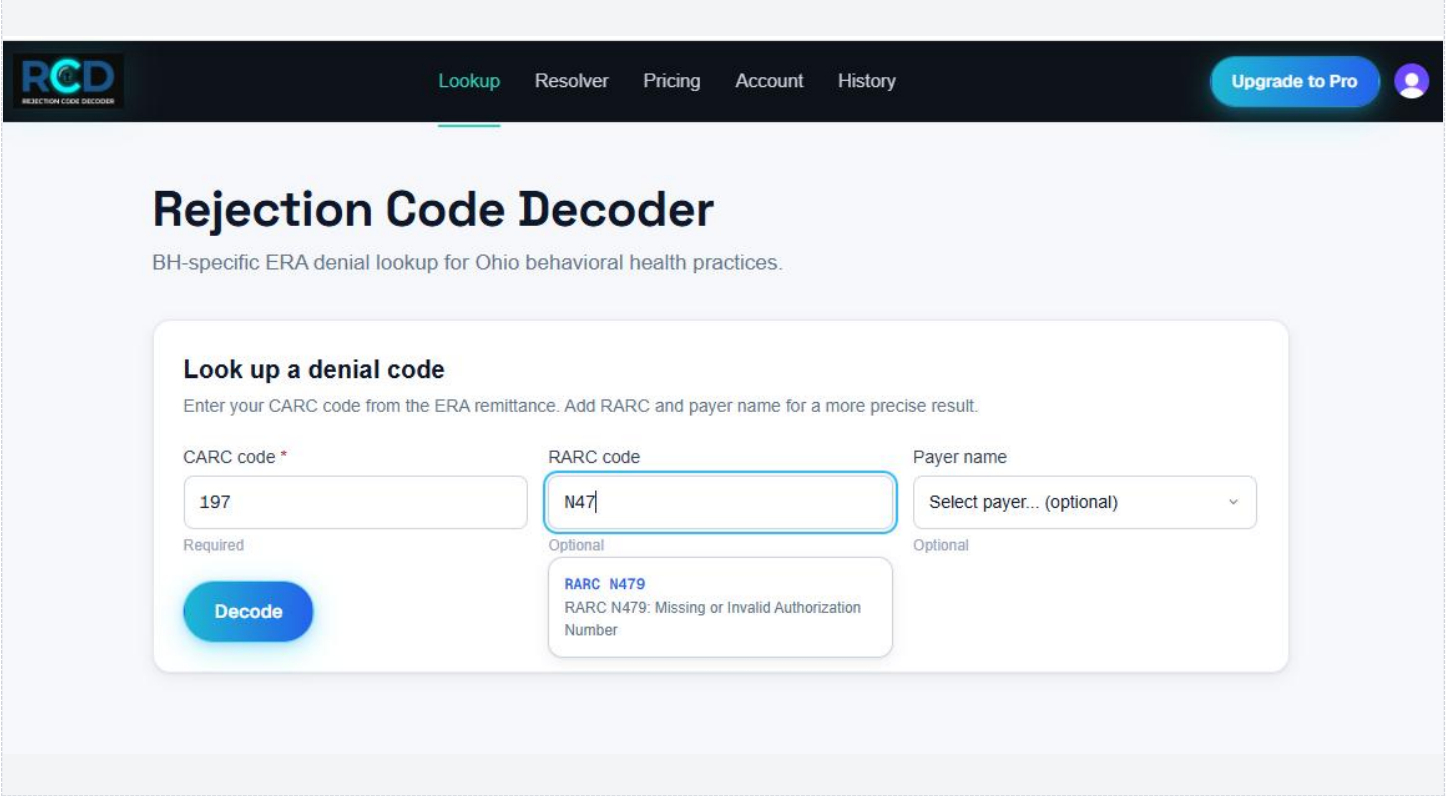

Figure: Type a RARC code in the remark code field. Both N-codes and MA-codes are supported.

TIP: When a CARC and RARC appear together, RCD checks for a combination-specific explanation that captures the unique meaning of that code pair. This is often more accurate than looking up each code separately.

Step 3 — Select Your Payer (Optional but Recommended)

In the "Payer" dropdown, select the insurance company that sent the denial. Selecting a payer unlocks Ohio-specific notes about how that payer handles this particular denial — including auth requirements, portal information, and appeal tips.

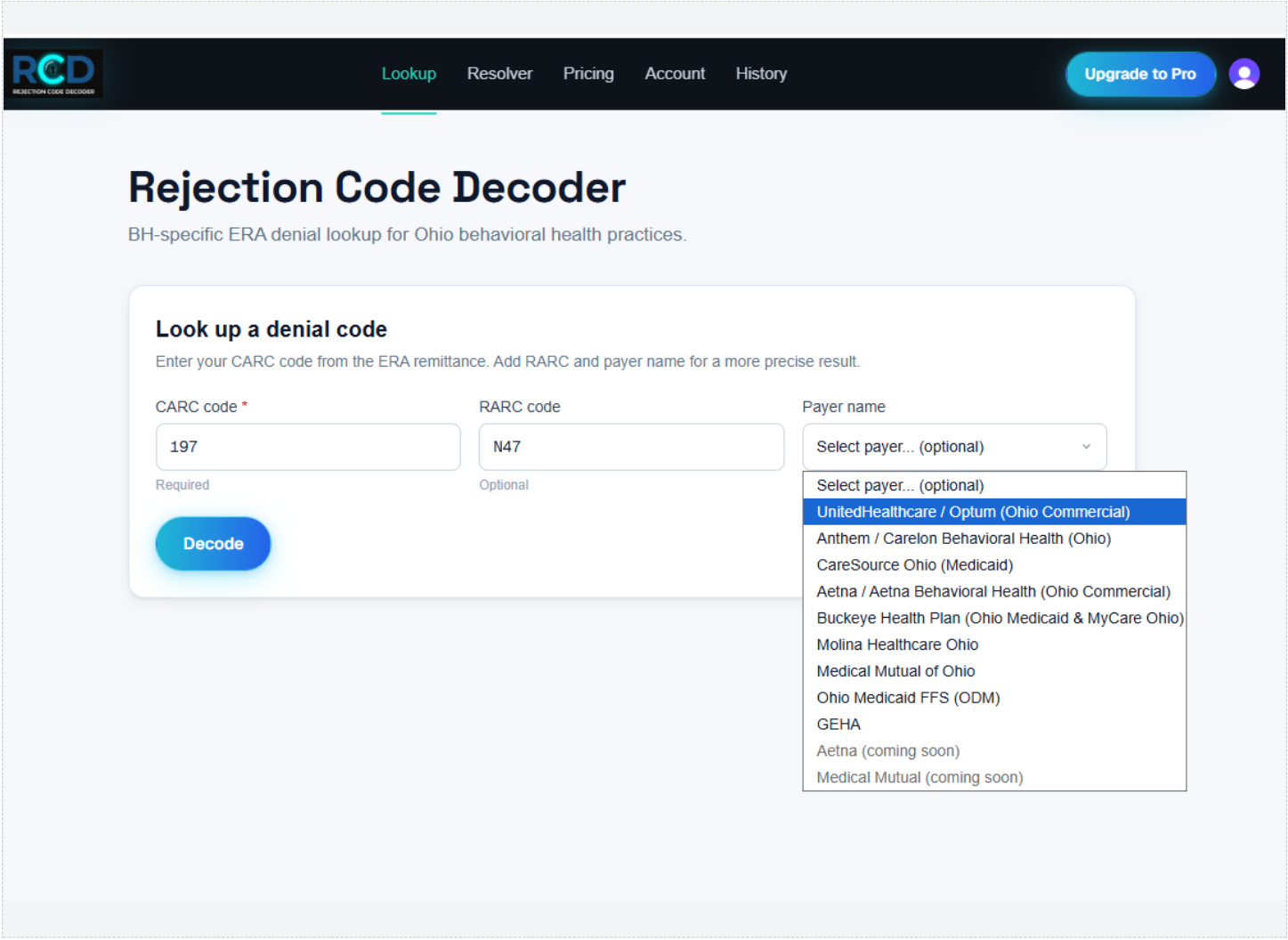

Figure: Select the payer from the dropdown. Only Ohio payers with verified content are listed.

Field / Element	Description
UnitedHealthcare / Optum (Ohio Commercial)	Optum-managed commercial plans in Ohio
Buckeye Health Plan (Ohio Medicaid & MyCare Ohio)	Ohio Medicaid and MyCare Ohio managed by Buckeye
CareSource Ohio (Medicaid)	Ohio Medicaid managed by CareSource
Molina Healthcare Ohio	Ohio Medicaid and marketplace plans
Anthem / Carelon Behavioral Health (Ohio)	Anthem commercial and Carelon BH carve-out
Ohio Medicaid FFS (ODM)	Ohio Department of Medicaid fee-for-service
GEHA	Federal employee health plan, BH-covered

NOTE: If your payer is not listed, run the lookup without a payer selected. You will still get the code explanation and general BH guidance — just without payer-specific notes. Additional payers (Aetna, Medical Mutual, OhioRISE) are being added after the July 2026 launch.

Step 4 — Run the Lookup

Click the "Look Up" or "Decode" button. Results appear immediately — there is no page reload.

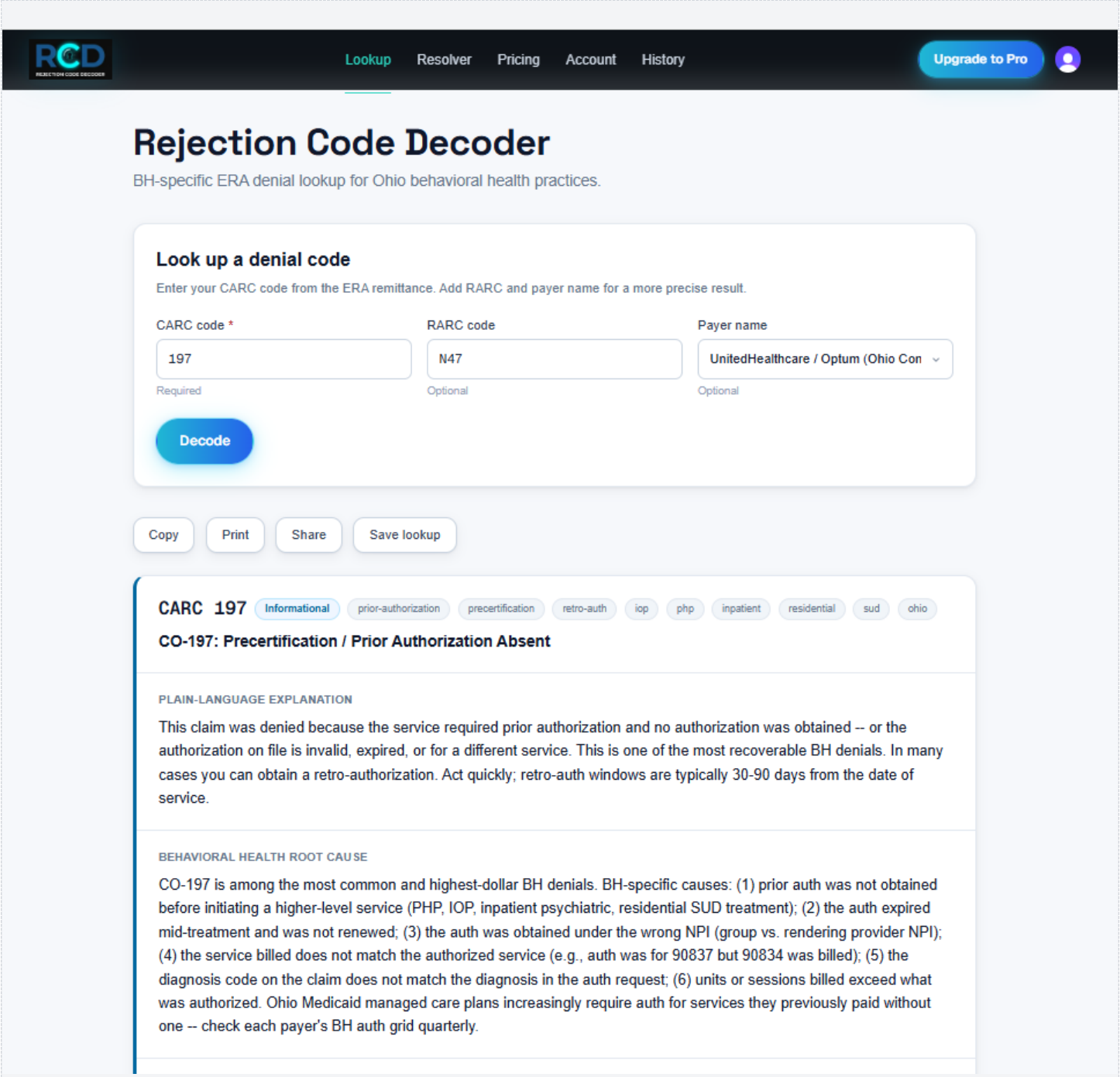

Figure: A full lookup result showing plain-language explanation, root cause, next steps, and payer notes.

3.3 Reading Your Results

Each lookup result includes several sections:

Field / Element	Description
Code Title	A short, plain-language name for what this code means (e.g., "Prior Authorization Required — BH Level of Care"). Replaces the official X12 technical description.
Plain Language Explanation	A 2–3 sentence explanation of why the claim was adjusted, written for billing coordinators — not for claims systems.
BH Root Cause	The most likely reason this denial happened in a behavioral health context. For example: "The authorization on file did not cover the level of care billed."
Next Steps	A numbered list of specific actions to take. Steps are ordered by priority — the most important action is listed first.
Payer-Specific Notes	Notes for the payer you selected, covering Ohio-specific rules, auth portal instructions, appeal paths, and timely filing deadlines. Appears only when a payer is selected.
Tags	Category labels for this code (e.g., "authorization," "timely filing," "NPI"). Useful for identifying patterns across denials.

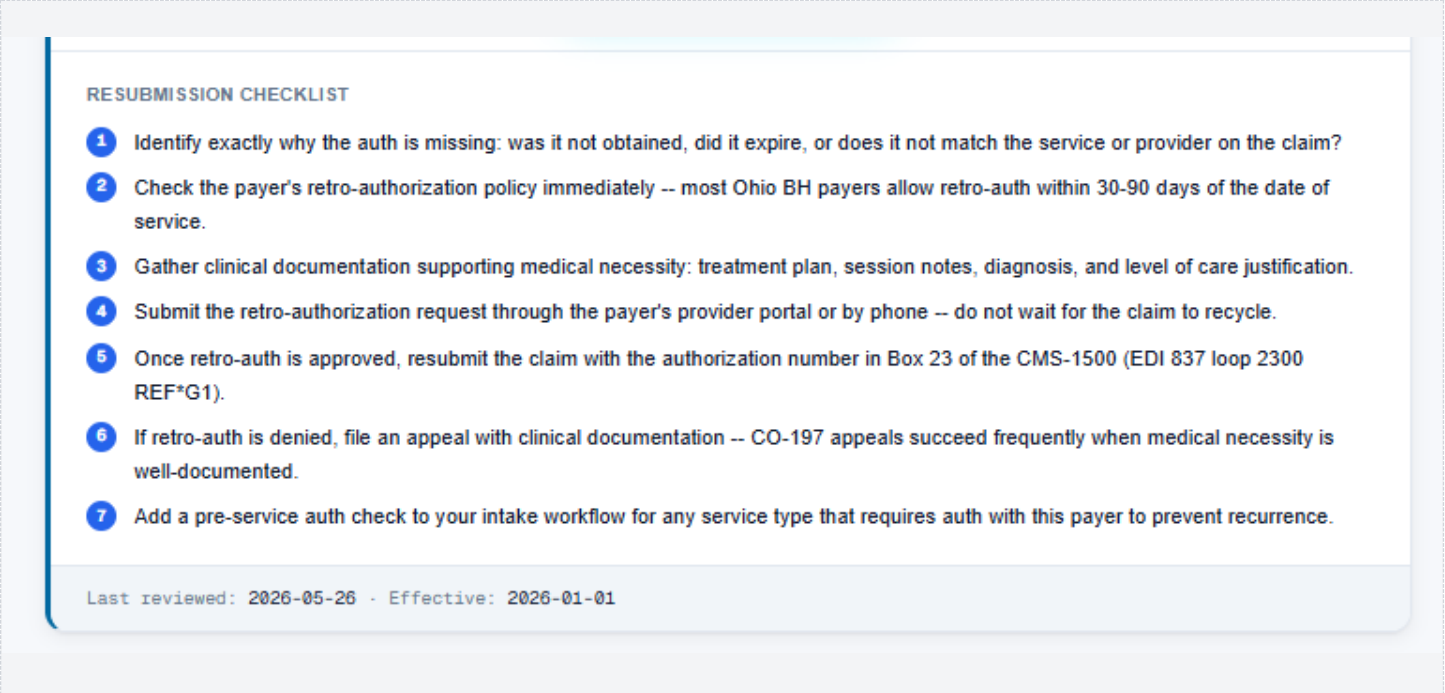

Figure: The Next Steps section provides a prioritized action list specific to this denial code.

TIP: Print or save the result page before closing it. On paid plans, every lookup is automatically saved to your Lookup History (/history).

3.4 Payer-Specific Notes

When you select a payer, the result page includes a "Payer Notes" section at the bottom of the result card. This section contains Ohio-specific guidance that goes beyond the generic code explanation — information that RCD's BH billing research team has verified against each payer's current provider manuals.

Payer notes may include:

- Which portal to use for prior authorization (e.g., Availity, NaviNet, payer-specific portal).
- Whether this payer requires BH to be authorized separately from medical.
- Timely filing deadlines specific to this payer.
- Appeal submission path (portal vs. fax vs. mail).
- Ohio-specific clinical criteria differences (e.g., IOP, PHP, residential SUD).

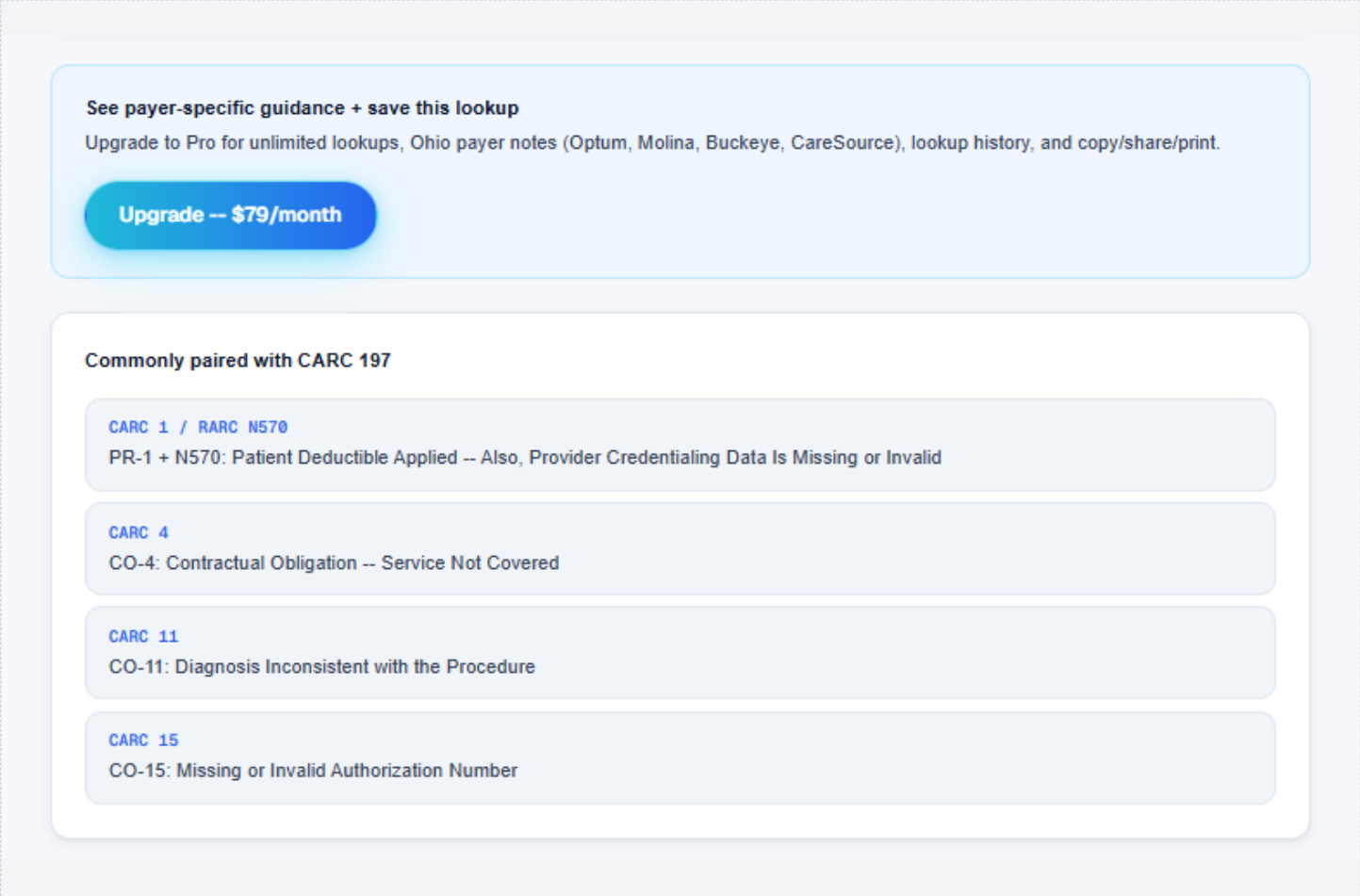

Figure: Payer-specific notes appear at the bottom of the result card when a payer is selected.

⚠ **IMPORTANT:** Payer notes reflect Ohio provider manual content as of June 2026. Always verify timely filing deadlines and portal information against your current provider manual, as payers update these periodically.

4. The Denial Resolver

4.1 What Is the Denial Resolver?

The Denial Resolver (/resolver) is an advanced feature that synthesizes a complete denial analysis from your CARC, RARC, and payer selection. While the basic Lookup page looks up each code individually, the Denial Resolver understands how codes interact with each other.

The key difference: when a CARC and RARC appear together on the same denial, their combination often carries a meaning that neither code conveys alone. The Resolver checks for these combination patterns first before synthesizing a result — this is what makes it more precise than a simple code lookup.

Example: CARC 197 (Authorization Required) alone tells you the claim needed auth. But CARC 197 + RARC N479 together means specifically "the authorization was obtained but was for a different level of care than what was billed." That is a very different action item — and the Resolver catches it.

NOTE: The Denial Resolver was added to RCD on June 14, 2026. It is available to all users (free and paid). Free-tier users: Resolver lookups count against your 5-lookup monthly limit.

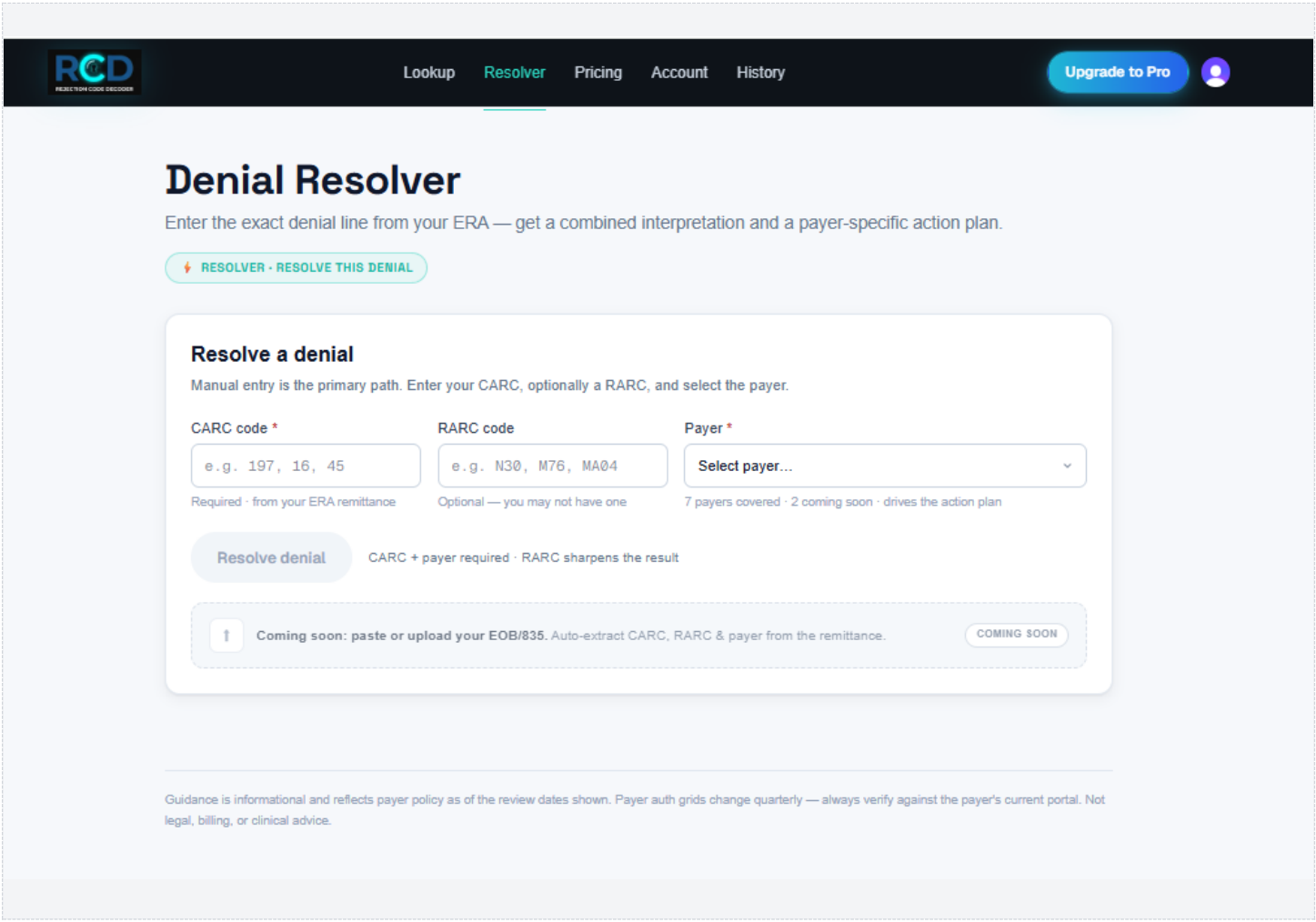

Figure: The Denial Resolver page. Enter CARC, RARC, and payer to get a synthesized denial analysis.

4.2 Running a Denial through the Resolver

The Resolver interface works the same way as the Lookup page — CARC, RARC, and payer — but the engine behind it is different.

9. Navigate to rejectioncodedecoder.com/resolver, or click "Denial Resolver" in the top navigation bar.
10. Enter the CARC code from your denial.
11. Enter the RARC code if one is present on the denial (strongly recommended for the Resolver).
12. Select your payer from the dropdown.
13. Click "Resolve Denial." The result appears immediately.

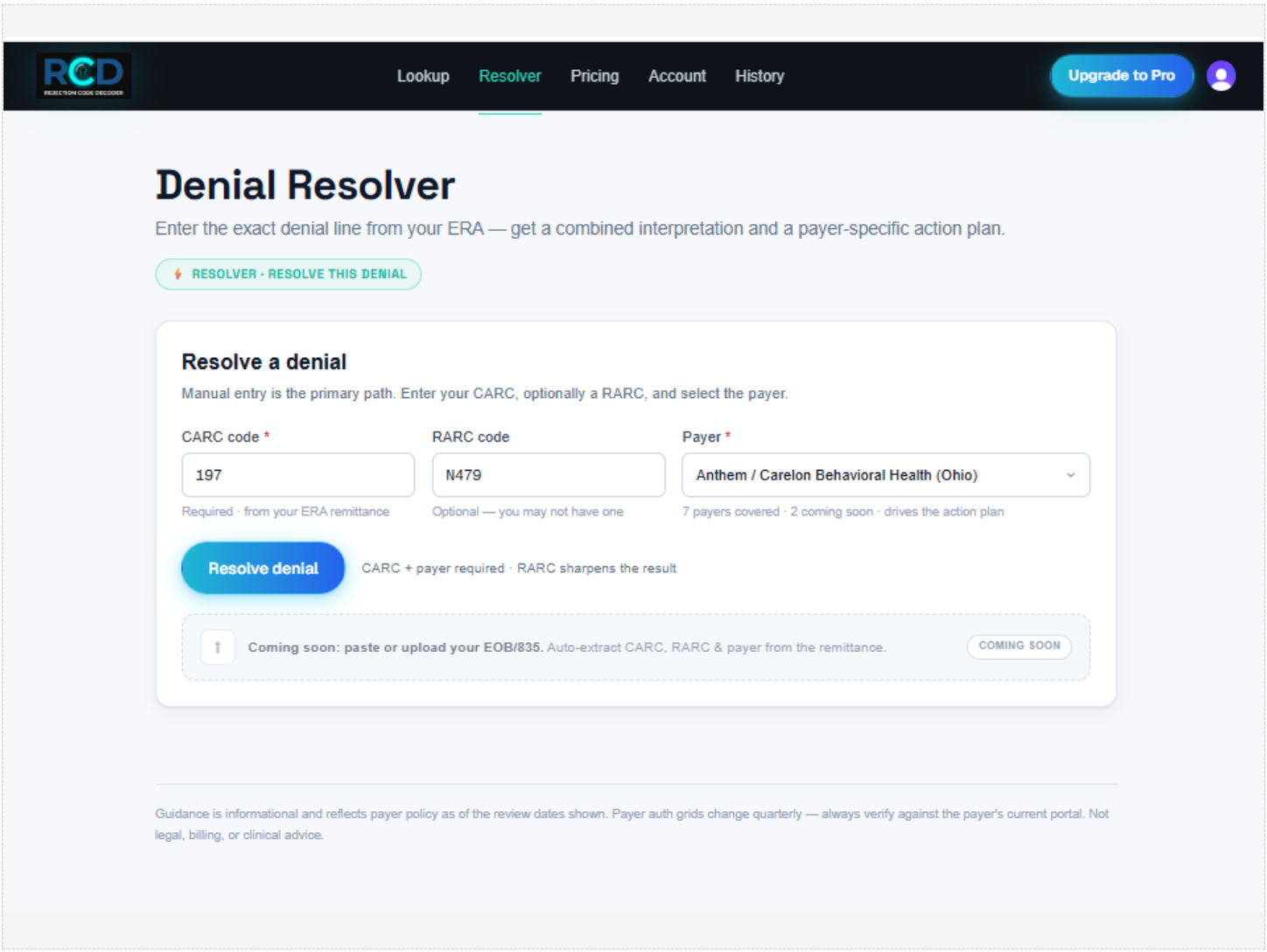

Figure: CARC 197, RARC N479, and Anthem selected. Click "Resolve Denial" to run the analysis.

TIP: For best results, always enter both the CARC and RARC when using the Resolver. The combination-detection logic requires both codes to identify combination-specific guidance.

4.3 Understanding the Resolver Output

The Resolver returns one of four result types depending on what information was matched:

Field / Element	Description
Full Result	CARC + RARC + payer all matched. The most complete result type — includes the synthesized denial explanation, BH root cause, next steps, and payer-specific notes.
Partial Result	CARC + RARC matched, but no payer was selected or the payer has no notes for this code. Returns the synthesized explanation and next steps without payer notes.
Payer Not Covered	CARC matched, but the selected payer does not have content for this code yet. Returns the general CARC explanation and notes that payer-specific content is pending.
Unknown	No match found for the entered codes. Check that the codes are entered correctly. If the codes are valid and still unmatched, this code may not yet be in the RCD content library.

RCD

Lookup | Resolver | Pricing | Account | History

Upgrade to Pro

Denial Resolver

Enter the exact denial line from your ERA — get a combined interpretation and a payer-specific action plan.

RESOLVER · RESOLVE THIS DENIAL

Resolve a denial

Manual entry is the primary path. Enter your CARC, optionally a RARC, and select the payer.

CARC code *: 197
Required · from your ERA remittance

RARC code: N479
Optional — you may not have one

Payer *: Anthem / Carelon Behavioral Health (Ohio)
7 payers covered · 2 coming soon · drives the action plan

Resolve denial

CARC + payer required · RARC sharpens the result

Coming soon: paste or upload your EOB/835. Auto-extract CARC, RARC & payer from the remittance. COMING SOON

Resolving: CARC 197 + RARC N479 on PAYER Anthem / Carelon Behavioral Health (Ohio)

Copy | Print | Share | Save to history

CARC 197 / RARC N479

Full match | Anthem / Carelon Behavioral Health (Ohio) | prior-authorization | precertification | retro-auth

CO-197: Precertification / Prior Authorization Absent — RARC N479: Missing or Invalid Authorization Number

COMBINED INTERPRETATION · free

This claim was denied on two fronts: this claim was denied because the service required prior authorization and no authorization was obtained -- or the authorization on file is invalid, expired, or for a different service. Additionally, the authorization number on the claim is absent, in the wrong format, or doesn't match the payer's records. Resolve the most specific issue first, then pursue recovery on the primary denial.

CARC 197 — This claim was denied because the service required prior authorization and no authorization was obtained -- or the authorization on file is invalid, expired, or for a different service. This is one of the most recoverable BH denials. In many cases you can obtain a retro-authorization. Act quickly; retro-auth windows are typically 30-90 days from the date of service.

RARC N479 — The authorization number on the claim is absent, in the wrong format, or doesn't match the payer's records. This is different from CARC 197 (no auth obtained) -- N479 means you have an auth but something about the number on the claim is wrong. Pull the authorization approval and compare the number character-by-character.

BEHAVIORAL HEALTH ROOT CAUSE · free

CO-197 is among the most common and highest-dollar BH denials. BH-specific causes: (1) prior auth was not obtained before initiating a higher-level service (PHP, IOP, inpatient psychiatric, residential SUD treatment); (2) the auth expired mid-treatment and was not renewed; (3) the auth was obtained under the wrong NPI (group vs. rendering provider NPI); (4) the service billed does not match the authorized service (e.g., auth was for 90837 but 90834 was billed); (5) the diagnosis code on the claim does not match the diagnosis in the auth request; (6) units or sessions billed exceed what was authorized. Ohio Medicaid managed care plans increasingly require auth for services they previously paid without one -- check each payer's BH auth grid quarterly.

Paired with RARC N479: N479 is a technical auth number entry error rather than a missing auth issue. Common causes: (1) the auth number was mistyped -- leading zeros, dashes, or payer-specific prefixes omitted; (2) the auth number was obtained from the wrong system (e.g., Optum auth number entered on a UHC medical claim); (3) the auth number belongs to a different rendering provider, service, or date range than what was billed; (4) for ODM FFS, the auth number generated through the PNM portal wasn't transcribed correctly to Box 23 of the CMS-1500.

ANTHEM / CARELON BEHAVIORAL HEALTH (OHIO) — ACTION PLAN · Pro

Anthem / Carelon Behavioral Health (Ohio) action plan — Pro subscribers only

See exactly how Anthem / Carelon Behavioral Health (Ohio) handles CARC 197 + RARC N479: retro-auth windows, portal steps, and specific recovery guidance.

Upgrade to Pro — $79/month

NEXT STEPS · generic, free

- [ ] 1. Pull the authorization approval letter or portal record and compare the auth number character-by-character to what was entered on the claim.
- [ ] 2. Verify the auth number belongs to the correct rendering provider, service type, and date range.
- [ ] 3. For Optum: confirm the auth number came from the Optum portal (providerexpress.com), not the UHC medical portal.
- [ ] 4. Resubmit as a corrected claim with the exact authorization number from the approval record in Box 23 of the CMS-1500.
- [ ] 5. Identify exactly why the auth is missing: was it not obtained, did it expire, or does it not match the service or provider on the claim?
- [ ] 6. Check the payer's retro-authorization policy immediately -- most Ohio BH payers allow retro-auth within 30-90 days of the date of service.
- [ ] 7. Gather clinical documentation supporting medical necessity: treatment plan, session notes, diagnosis, and level of care justification.
- [ ] 8. Submit the retro-authorization request through the payer's provider portal or by phone -- do not wait for the claim to recycle.
- [ ] 9. Once retro-auth is approved, resubmit the claim with the authorization number in Box 23 of the CMS-1500 (EDI 837 loop 2300 REF*G1).
- [ ] 10. If retro-auth is denied, file an appeal with clinical documentation -- CO-197 appeals succeed frequently when medical necessity is well-documented.
- [ ] 11. Add a pre-service auth check to your intake workflow for any service type that requires auth with this payer to prevent recurrence.

Sources: CARC 197 reviewed **2026-05-26** · RARC N479 reviewed **2026-06-02** · Effective **2026-01-01**

See the Anthem / Carelon Behavioral Health (Ohio) action plan + save this denial

Upgrade to Pro for unlimited resolves, payer-specific action plans for all 7 Ohio plans (Optum, Carelon, CareSource, Buckeye, Molina, ODM, GEHA), resolve history, and copy/share/print.

Upgrade — $79/month

Figure: A Full Result from the Denial Resolver. All four result sections are populated.

The "Combination Override" badge appears at the top of the result when the Resolver found a specific entry for this exact CARC+RARC combination — meaning the result is not synthesized from two separate entries but comes from a single, combination-specific content record.

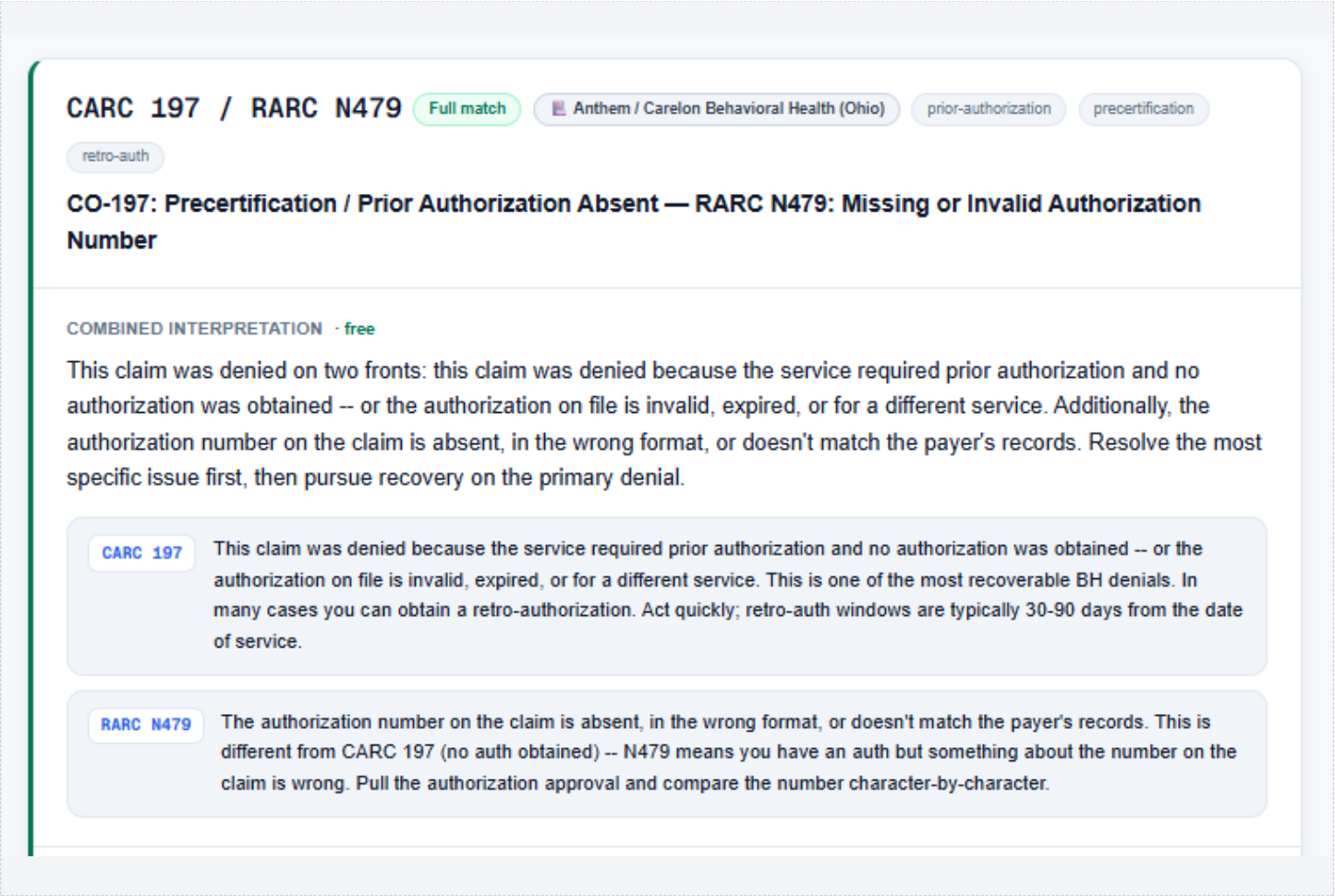

Figure: The "Combination Override" badge indicates the result came from a CARC+RARC specific entry.

5. Lookup History

The Lookup History page (/history) shows every code lookup you have run while signed in. This is available to all registered users — both free and paid.

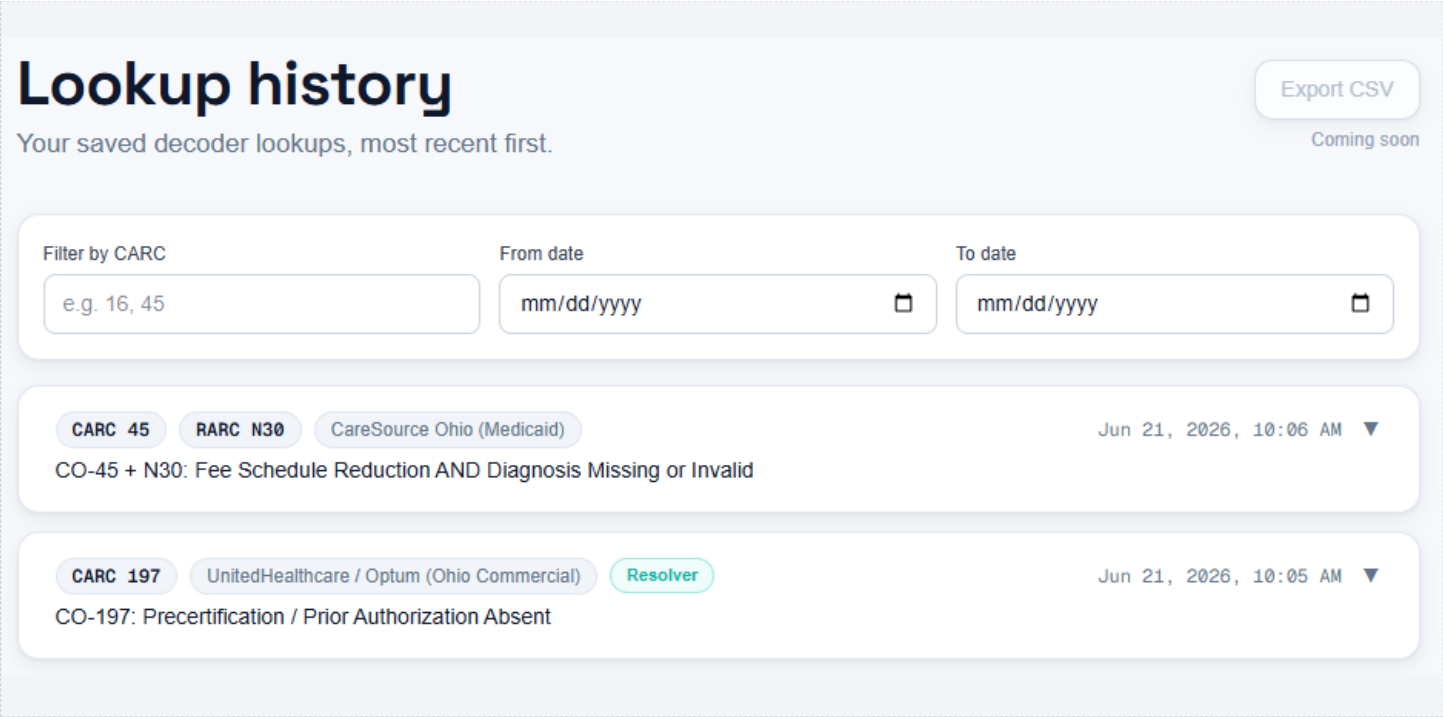

Figure: The Lookup History page shows all past lookups with code, payer, and timestamp.

Each history entry shows:

- The CARC and/or RARC code you searched.
- The payer you selected (if any).
- The date and time of the lookup.
- A "View Result" link to re-open the full result.

NOTE: Lookup History only captures lookups made while you are signed in. Lookups made before account creation are not retroactively added to your history.

TIP: Use Lookup History to track which denials you have already researched and to build a reference library of the codes you see most often at your practice.

6. Managing Your Account & Subscription

6.1 Account Settings

Your account settings are available at rejectioncodedecoder.com/account. From this page you can:

- Update your email address.
- Change your password.
- View your current plan (Free or Paid).
- Manage your billing information (paid subscribers).
- Access the Customer Portal to update your payment method or cancel.

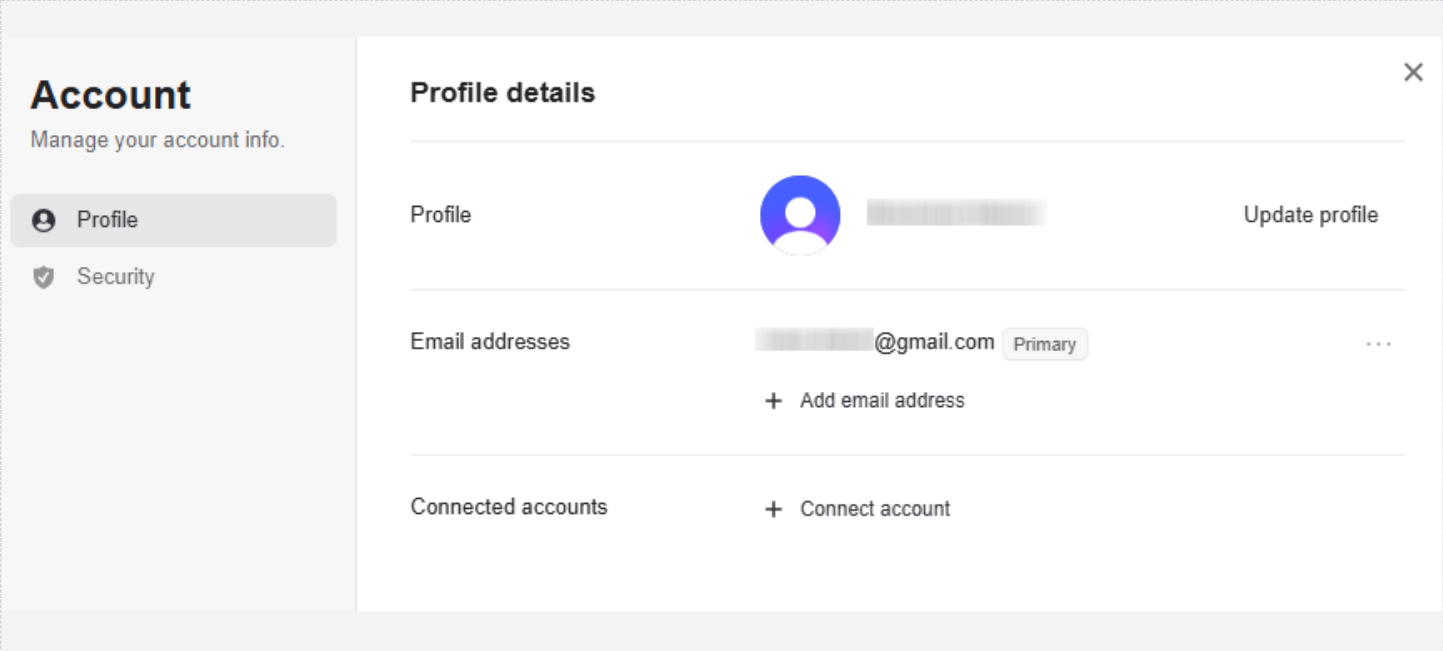

Figure: The Account page shows your plan status, lookup usage, and billing management options.

6.2 Upgrading to Paid ($79/month)

You can upgrade from the free tier to the paid plan at any time from the Pricing page or your Account page.

14. Click "Upgrade" on the /pricing page or /account page.
15. You will be redirected to a secure Stripe Checkout page.
16. Enter your credit card information. Stripe handles all payment processing — RCD does not store your card details.
17. Click "Subscribe." Your plan upgrades immediately.
18. You will be redirected back to RCD with your paid access active.

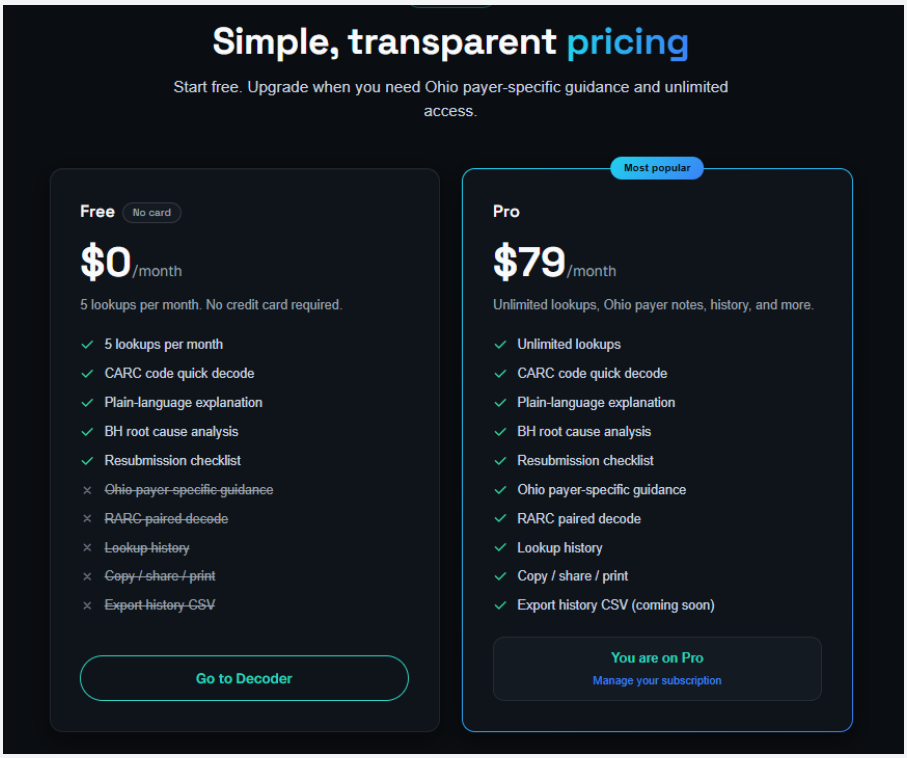

Figure: The Pricing page. Click "Get Started" under the Paid plan to upgrade.

NOTE: Billing is monthly. Your subscription renews on the same date each month. You will receive a receipt by email after each billing cycle.

6.3 Cancelling Your Subscription

You can cancel your paid subscription at any time. Cancellation takes effect at the end of your current billing period — you will not be charged again, and you retain paid access until the period ends.

19. Go to your Account page (/account).
20. Click "Manage Billing" or "Customer Portal."
21. In the Stripe Customer Portal, click "Cancel Plan."
22. Confirm the cancellation. You will receive an email confirmation.

TIP: After cancellation, your lookups reset to the free tier (5/month) at the next billing cycle. Your lookup history remains accessible.

7. Payer Coverage

RCD currently includes payer-specific notes for the following Ohio BH payers. Content has been verified against each payer's current Ohio provider manual.

Payer	Coverage Type	Status
UnitedHealthcare / Optum (Ohio Commercial)	Commercial — BH managed by Optum	Live
Buckeye Health Plan	Ohio Medicaid & MyCare Ohio	Live
CareSource Ohio	Ohio Medicaid	Live
Molina Healthcare Ohio	Medicaid & Marketplace	Live
Anthem / Carelon Behavioral Health	Commercial — BH carve-out via Carelon	Live
Ohio Medicaid FFS (ODM)	Fee-for-service Medicaid	Live
GEHA	Federal employee health plan	Live
Aetna / Aetna Behavioral Health (Ohio)	Commercial	Coming Soon
Medical Mutual of Ohio	Commercial	Coming Soon
OhioRISE (Aetna Better Health of Ohio)	Children's BH Medicaid	Coming Soon

"Coming Soon" payers are visible in the Resolver dropdown but are grayed out and cannot be selected until their content is available. These payers are expected to be live in the second half of 2026.

If your payer is not listed, run your lookup without selecting a payer. You will still receive the code explanation and general BH guidance — just without Ohio-payer-specific notes.

8. Glossary of Terms

Field / Element	Description
CARC	Claim Adjustment Reason Code. A numeric code (e.g., 97, 197) that explains why a claim payment was adjusted or denied. Defined by the X12 EDI standard. Appears on all EOBs and ERAs.
RARC	Remittance Advice Remark Code. An alphanumeric code (e.g., N479, MA01) that provides additional context about a claim adjustment. Often accompanies a CARC but can appear alone.
EOB	Explanation of Benefits. The document a payer sends to a provider (and sometimes patient) after processing a claim. Shows the service billed, payment, adjustments, and denial codes.
ERA	Electronic Remittance Advice. The electronic version of the EOB (ANSI X12 835 transaction), received through your clearinghouse or practice management system.
X12	The standards organization that defines CARC and RARC codes and the 835 ERA transaction format. All CARC and RARC codes in RCD are sourced from the official X12 code lists.
BH	Behavioral Health. Used throughout RCD to refer to mental health and substance use disorder (SUD) services.
IOP	Intensive Outpatient Program. A structured BH treatment program that meets 3+ days/week, typically 3 hours/session.
PHP	Partial Hospitalization Program. A BH treatment program more intensive than IOP, typically 5 days/week, 4–6 hours/session.
Prior Auth	Prior Authorization. Pre-approval from the insurance payer before rendering certain services. Many BH services (IOP, PHP, residential, inpatient psychiatric) require prior auth.
LOC	Level of Care. The clinical intensity of a BH service (e.g., outpatient, IOP, PHP, residential, inpatient). Auth denials often involve a mismatch between the LOC authorized and the LOC billed.
Carve-Out	When a payer contracts with a separate behavioral health organization (e.g., Carelon, Optum) to manage BH claims separately from medical claims. BH auths and appeals go to the carve-out entity, not the medical payer.
NPI	National Provider Identifier. A unique 10-digit number assigned to each healthcare provider. CARC 16 and similar codes often relate to NPI issues.
Timely Filing	The deadline by which a claim must be submitted to a payer after the date of service. Missing the timely filing window results in a denial that typically cannot be appealed.
Denial Resolver	RCD's synthesis engine that analyzes CARC + RARC combinations to produce a more precise denial explanation than a single-code lookup. Available at /resolver.
Combination Override	A content entry in RCD written specifically for a CARC+RARC pair, capturing the unique meaning of that combination. Takes precedence over synthesized results in the Resolver.

9. Frequently Asked Questions

Does RCD store patient data or claim information?

No. RCD is a code reference tool — it does not ask for, accept, or store any patient names, dates of service, claim numbers, diagnosis codes, or other protected health information (PHI). Your lookup history records only the codes you searched and the timestamp.

Why does my lookup show "Unknown" or "No Result Found"?

This means the code combination you entered is not yet in the RCD content library. The most common reasons: (1) the code is less common in BH billing and has not yet been added to the library; (2) the code was entered with a typo — double-check the CARC and RARC against your EOB. If you are certain the codes are correct, please use the Contact page to let us know — we prioritize adding new codes based on user requests.

My payer is not in the dropdown. Can I still use RCD?

Yes. Run the lookup without selecting a payer. You will receive the full code explanation, BH root cause, and next steps — just without Ohio-payer-specific notes. We are continuously adding new payers. Contact us at /contact to request a payer.

What is the difference between using /lookup and /resolver?

The Lookup page (/lookup) retrieves the explanation for a single code. The Denial Resolver (/resolver) analyzes how the CARC and RARC interact — it detects combination patterns and synthesizes a more precise result when you have both codes. Use the Resolver when you have both a CARC and a RARC on the same denial.

I upgraded to paid but still see the lookup counter. What do I do?

Try signing out and signing back in. Your plan status is confirmed when your session refreshes. If the issue persists after signing back in, contact us at /contact and include your account email address.

How often is the code content updated?

RCD's content team reviews and updates code entries on a rolling basis, with major content reviews when X12 releases updated CARC/RARC lists (typically quarterly). Payer-specific notes are updated when a payer updates its Ohio provider manual. The "Last Reviewed" date on each result entry shows when that entry was last verified.

Is RCD HIPAA compliant?

RCD is designed to collect zero PHI — there is no patient data field in the application and no PHI is transmitted or stored at any point. Because no PHI is involved, RCD does not function as a Business Associate under HIPAA. Always ensure you do not enter any patient-identifying information into the lookup fields.

Can I use RCD on my phone?

Yes. RCD is fully responsive and designed to work well on smartphones and tablets. The lookup interface adapts to smaller screens — the results stack vertically below the input fields on mobile.

10. Getting Help

If you run into an issue, have a question not covered in this manual, or want to request a new payer or code, we are here to help.

Field / Element	Description
Contact Form	Go to rejectioncodedecoder.com/contact and submit your question. We respond within 1 business day.
Email	You can also reach us directly via the contact form. We do not publish a direct email address to avoid spam.
Request a Code	If a code you need is not in RCD, tell us on the Contact page — we prioritize code additions based on what billers are actually seeing.
Request a Payer	If your Ohio payer is not in the payer list, contact us. We are actively adding new payers and welcome specific requests.
Billing Issues	For subscription and billing questions, go to your Account page (/account) and click "Manage Billing." For refund requests, use the Contact form.

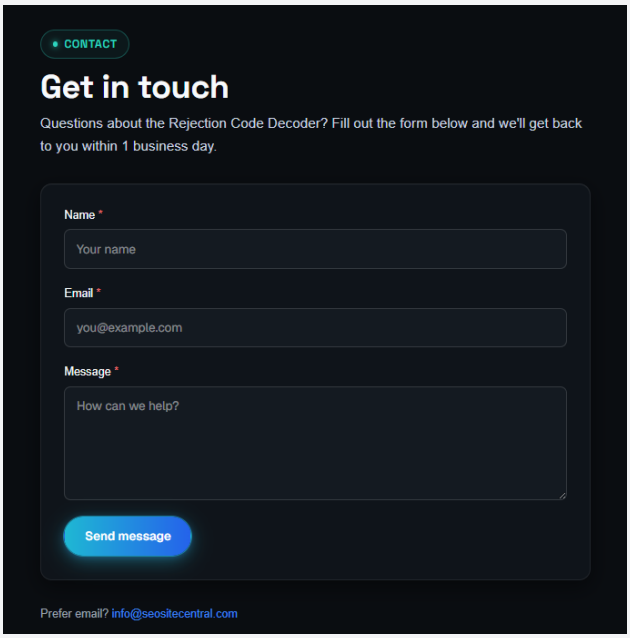

Figure: The Contact page. Use this form to submit questions, code requests, or payer requests.