APPENDIX G. PROMPT PAY FORM

PROMPT PAY FORM

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, Ok 73112-4511

(405) 521-2828
(800) 522-0071 Toll Free (In State Only)
(405) 521-6632 Fax

NOTE:
ENTITIES ACCUSED OF PROMPT PAY VIOLATIONS ARE REQUIRED TO SUBMIT DOCUMENTATION SUPPORTING THE REASON FOR DELAY IN PAYMENT OR PROOF OF PAYMENT TO THE OKLAHOMA INSURANCE DEPARTMENT WITHIN TEN (10) DAYS.

FROM: _____ **Telephone:** _____

Address: _____ **City & State:** _____ **Zip:** _____

Name of insured or member: _____ **Telephone:** _____

Address: _____ **City & State:** _____ **Zip:** _____

Full Name of Entity accused of prompt pay violations: _____

Address: _____ **City & State:** _____ **Zip:** _____

Policy/Contract/Group Number or Name: _____

Dates Claims Originally Submitted: _____

Please give as detailed information as possible including dates and explain what solution you feel is correct. Attach copies of all correspondence relating to the inquiry. Include the following information if available: 1) Provider PIN such as health plan/company ID/tax ID; 2) Member ID number; 3) Date of original claim filing; 4) Date of service; 5) Billed amount for the service; and 4) description of the service or CPT code involved.

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(Continue on the back)

COMPLAINANT MUST PROVIDE A COPY OF THIS COMPLETED FORM TO THE ENTITY ACCUSED OF PROMPT PAY VIOLATIONS AND THE OKLAHOMA INSURANCE DEPARTMENT SIMULTANEOUSLY.