HOW TO AVOID FILING ERRORS

Know your contractual obligations, including where to file claims, claim filing deadlines, and your fee schedule.

File claims to the correct address; file claims with carriers in a timely manner.

File claims using a method that documents when the claim was received by the carrier.

Keep records of your phone conversations and all written correspondence with each carrier regarding status of a claim.

Update your accounts receivable as soon as claim payments are received.

Evidence of your collection activities for each claim prior to contacting the Oklahoma Insurance Department.

That evidence should be in the form of:

1. Documentation of phone conversations made to health carrier
2. Copies of correspondence mailed to the health carrier
3. Replies you have received from the health carrier

Be sure to separate claims by the insurance carrier name. Claims for one insurance carrier must be grouped together and all written correspondence submitted with them.

Be sure to separate claims by the same patient, please staple the forms together.

Accurate claim submission can prevent most claim problems. Make sure your claim forms are filled out completely and accurately and that you use the insurance company’s correct mailing address. If possible, submit your claim forms electronically.

Electronic clearinghouses reject claims submitted with incomplete, invalid, or incorrect member identification numbers. If an insurance company returns a claim because of mistakes, correct them immediately and resubmit the claim to meet the filing deadline specified in your contract.

Evidence of claim submission in the form of:

1. Electronic filing
2. Certified mail receipt, or
3. Courier delivery confirmation

FILING ERRORS

HOW TO AVOID

Evidence of your collection activities for each claim prior to contacting the Oklahoma Insurance Department.

That evidence should be in the form of:

1. Documentation of phone conversations made to health carrier
2. Copies of correspondence mailed to the health carrier
3. Replies you have received from the health carrier

Be sure to separate claims by the insurance carrier name. Claims for one insurance carrier must be grouped together and all written correspondence submitted with them.

Be sure to separate claims by the same patient, please staple the forms together.

Accurate claim submission can prevent most claim problems. Make sure your claim forms are filled out completely and accurately and that you use the insurance company’s correct mailing address. If possible, submit your claim forms electronically.

Electronic clearinghouses reject claims submitted with incomplete, invalid, or incorrect member identification numbers. If an insurance company returns a claim because of mistakes, correct them immediately and resubmit the claim to meet the filing deadline specified in your contract.

Evidence of claim submission in the form of:

1. Electronic filing
2. Certified mail receipt, or
3. Courier delivery confirmation

Witnesses/Expert Witnesses

Proposed settlement offers

Litigation and impacting claims

TRICARE/CHAMPUS

PGPA TRICARE SOUTH UNIT

Foundation Health Federal Services, Inc.

PO. Box 8958

Madison, WI 53708

920-887-9000 or 800-752-9475

www.healthchoiceok.com

OKLAHOMA

INSURANCE

AUTHORIZED

REGULATORY

AUTHORITY

The Oklahoma Insurance Department regulates insurance transactions within the state of Oklahoma.

OUT OF STATE INSURED

OID regulates insurance transactions within the state of Oklahoma. If you purchased your contract in another state, contact that state’s insurance department.

HELPFUL ADDRESSES

ERISA

(ERISA (self-funded plans through an employer)

U.S. Department of Labor

Dallas Address

Federal Building, Room 707

525 Griffin Street

Dallas, TX 75202

866-444-3272

www.dol.gov/esa

STATE EMPLOYEES

(Health Choice) (State Retirement)

Oklahoma State & Education Employee Group Insurance Board (OSEEGB)

3545 NW 58th, Suite 110

Oklahoma City, OK 73112

(405) 717-8701 or 800-752-9475

www.healthchoicok.com

FEDERAL EMPLOYEES

(U.S. Postal Workers)

U.S. Office of Personnel Management

Employee Retirement and Insurance Group

PO. Box 436

Washington, DC 20044

(202) 606-0777

TRICARE/CHAMPUS

PGPA TRICARE SOUTH UNIT

Foundation Health Federal Services, Inc.

PO. Box 8958

Madison, WI 53708

920-887-9000 or 800-752-9475

www.chns.org

OUT OF STATE INSURED

OID regulates insurance transactions within the state of Oklahoma. If you purchased your contract in another state, contact that state’s insurance department.
A. In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of the claim by the insurer.

B. As used in this section:
1. “Accident and health insurance policy” or “policy” means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state, and any subscriber certificate or any evidence of coverage issued by a health maintenance organization to any person in this state;
2. “Clean claim” means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and
3. “Insurer” means any entity that provides an accident and health insurance policy in this state, including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a health maintenance organization, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.

C. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy. Provided, if a claim is not submitted into the system due to a failure to meet basic Electronic Data Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA) edits, electronic notification of the failure to the submitter shall be deemed compliance with this subsection. Provided further, health maintenance organizations shall not be required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee or subscriber of any claim defect or impropriety.

D. Upon receipt of the additional information or corrections which led to the claim’s being delayed and a determination that the information is accurate, an insurer shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on:
1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or
2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney fee to be set by the court and taxed as costs against the party or parties who do not prevail.

H. The Insurance Commissioner shall develop a standardized prompt pay form for use by providers in reporting violations of prompt pay requirements. The form shall include a requirement that documentation of the reason for the delay in payment or documentation of proof of payment must be provided within ten (10) days of the filing of the form. The Commissioner shall provide the form to health maintenance organizations and providers.

I. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.