

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Appendix NN. Patient's Affidavit [NEW]

Appendix OO. Provider Assistance Form [NEW]

AUTHORITY:

Insurance Commissioner; 36 O.S. §§ 307.1, 1250.16 and 1250.17

DATES:

Adoption:

June 29, 2010

Effective:

Immediately upon approval by the Governor

Expiration:

Effective through July 14, 2011, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY RULES:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

A compelling public interest requires the emergency rule due to House Bill 1055. House Bill 1055 mandates the Insurance Commissioner to promulgate a rule in the form of an affidavit to be presented to patients by health care providers prior to rendering nonemergency services. Continuing conversations with entities involved in the creation of House Bill 1055 delayed implementation of the affidavit. Therefore, the affidavit should be implemented as soon as possible. Additionally, to assist the health care providers involved in the creation of House Bill 1055 with immediate, ongoing concerns of unfair claims settlement practices, a provider assistance form should be promulgated as soon as practicable.

ANALYSIS:

The new Appendix NN creates the Patient's Affidavit, as required by House Bill 1055. The affidavit is to be used by health care providers prior to rendering nonemergency services. The affidavit requires a patient, or the legal guardian of the patient, to verify that that the patient is an insured individual under the health benefit plan presented to the provider. The new Appendix OO creates the Provider Assistance Form whereby providers of medical services can submit requests for assistance to the Oklahoma Insurance Department when the providers have a complaint or issue that they feel cannot be reconciled without assistance from the Oklahoma Insurance Department.

CONTACT PERSON:

Melanie Pouncey Sullivan, Oklahoma Insurance Department, (405) 521-2749

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S. SECTION 253(D):

APPENDIX OO. PROVIDER ASSISTANCE FORM [NEW]

PROVIDER ASSISTANCE FORM

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th, Suite 100
Oklahoma City, OK 73112
(405) 521-2991
(800) 522-0071 Toll Free (In State Only)
(405) 521-6652 Fax

Provider or Physician: _____ Telephone: _____
Address: _____ City & State: _____ Zip: _____

Name of patient: _____ Telephone: _____
Address: _____ City & State: _____ Zip: _____

Full Name of Insurance Company or HMO: _____
Address: _____ City & State: _____ Zip: _____
Policy/Contract/Group Number or Name: _____
Dates Claims Originally Submitted: _____

Please note that pursuant to 36 O.S. § 1219, insurers are required to 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 clean claim by the insurer. A clean claim is defined as “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.”

If the answer to either of the following questions is yes, then it is NOT proper for you to submit this form at this time:

1. Has it been less than 45 days since you sent the claim to the insurer?
2. Has the insurer advised that information is lacking, insufficient or that more information is necessary to process the claim?

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.

(Continue on the back)

FOR INSURANCE DEPARTMENT USE ONLY

Complaint Number _____ Claim Analyst _____
Complainant type _____ Complainant letter _____
Entity number 1. _____ 2. _____ 3. _____
Entity type 1. _____ 2. _____ 3. _____
Entity function 1. _____ 2. _____ 3. _____

Date Entered _____
Coverage _____ 1. _____ 2. _____ 3. _____
Reason for complaint 1. _____ 2. _____ 3. _____
Dispositions 1. _____ 2. _____ 3. _____
Inquirer _____
(If not same as shown above)