Claim Processing Guide

1. Claim Submission Process

Claims should be submitted within 90 days of service date. Electronic submission is preferred and results in faster processing times (typically 7-14 days vs 21-30 days for paper claims).

2. Required Documentation

All claims must include:

• Completed claim form (CMS-1500 or UB-04)

• Patient demographics and insurance information

• Provider information and NPI number

• Date(s) of service

• Diagnosis codes (ICD-10)

• Procedure codes (CPT/HCPCS)

• Itemized bill or statement

• Medical records (if requested)

3. Processing Timeline

Claim Type	Processing Time	Payment Time
Clean Electronic Claim	7-14 days	3-5 days after approval
Clean Paper Claim	21-30 days	5-7 days after approval
Claim Requiring Review	30-45 days	5-7 days after approval
Appeal/Reconsideration	45-60 days	7-10 days after approval

4. Common Denial Reasons and Resolution

Understanding why claims are denied helps prevent future rejections:

Denial Reason	Resolution Action
Pre-authorization not obtained	Obtain retro-authorization if possible
Not medically necessary	Submit clinical documentation
Out of network provider	File out-of-network claim or appeal

Service not covered	Review policy benefits
Insufficient documentation	Submit complete medical records
Duplicate claim	Verify claim status and resubmit if needed
Incorrect coding	Review and correct CPT/ICD codes

5. Appeals Process

Members and providers have the right to appeal denied claims within 180 days of the denial notice. Appeals should include:

• Written appeal letter stating reasons for disagreement

• Supporting clinical documentation

• Relevant medical literature or guidelines

• Provider's clinical rationale