DENIALS

**Denial Management:**

Basically, we have some denials that are as follows:

* Authorization (197)
* Referral (PR 165)
* Bundle (M 15)
* Timely Filling Limit ( TFL ) (PI 29)
* Primary EOB or Claim Services Not Covered by This contractor or Missing Primary Eob (PR 22)
* Medically Not Necessity
* Co-Ordination Of Benefits
* Pre Exisisitng Condition
* Non cover Service
* Coverage Terminated or Expenses incurred after coverage Terminated
* Global
* Maximum Benefits
* Duplicate
* Out of Network Provider
* Cpt code is incorrect for cpt code
* Modifier Is Inconsistent with cpt code
* Cpt Code Exceeded no of units
* Primary Paid Maximum or Primary Paid more than Secondary Allowed Amount
* Patient In Hospice

**NON DENIALS**

* Offset
* Capitation
* Deductible
* Claim Paid
* Claim in Process
* Claim not Found or claim not on file.

**Key Words**:

Provider=Doctor,

Number is denoted as #,

Claim number is mentioned as Claim#,

Denied = Dnd,

Date of service = DOS,

Timely Filing Limit =TFL

Representative= rep

**DENIAL:**

IT IS THE INFORMATION MENTIONED IN DENIED CLAIM EOB.

**DENIED**:

STOPPED THE CLAIM FROM MAKING THE PAYMENT

**DENIAL MANAGEMENT:**

QUESTIONS WHICH WE ARE ASKING FOR EACH DENIAL

**1 AUTHORIZATION: or Pre-Certification (Denial Code 197)**

Provider has to take permission from the INSURANCE COMPANY is called authorization.

It is of 2 types:

* Prior authorization: It has to take permission before service
* Retro authorization : It has to take permission after service

**Explanation to TL:**

* I will verify the denial.
* I will get the denied date.
* I will verify in my system whether we have any authorization number available or not.
* If authorization# is available. I will ask them to reprocess the claim.
* If authorization# is not available. I will ask for Retro authorization.
* If Retro authorization is not possible. I will ask them can I send an appeal with medical records.
* For sending an appeal, I will get the Fax number (or) Mailing address.
* I will get TFL for appeal.
* I will get claim number and reference number.

**If Authorization# is available:**

* May I know the denial.
* Can I get denied date.
* I verified in my system, I have an authorization number for this DOS can u please verify whether it is valid or not.
* (If Rep said it is valid)
* Can u reprocess the claim.
* May I know how many days it will take to reprocess the claim.
* Can I get claim number .Reference number.

**if Authorization# not available:**

* May I know the denial
* Can I get the denied date.
* Can I get retro authorization #.
* (if Rep said retro auth is not possible )
* Can I send appeal with Medical Records.
* can I get fax number and mailing address.
* Can I get Timely filing limit for appeal.
* Can I get claim and reference number.

**AUTHORIZATION NUMBER BLOCK IN CMS 1500 FORM = 23 BLOCK**

* If Place of service is related to 23 and we have received a denial authorization what u will do in this case?
* POS 23 is related to EMERGENCY and for emergency services authorization is not needed I Will call to insurance company and I will ask them to reprocess the claim
* Who has to take permission from insurance company?
* Provider office has to take permission from Insurance Company

**RENDERING PROVIDER:**

Rendering provider is the provider who provides actual service.

**REFERRING PROVIDER or primary care physician or family doctor :**

Referring provider is the provider who provides initial service.

**2 REFERAL : (Denial Code PR 165)**

It is the process of sending patient from one provider to another provider for special service.

**Explanation of TL:**

* I will verify the denial.
* I will get the denied date.
* I will verify who is the PCP (primary care physician) for this patient.
* I will verify in my system whether we have any referral# available on this claim or not.
* I referral# is available, I will ask them to reprocess the claim.
* If referral is not available. I will ask the PCP Name and Phone Number.
* I will get the TFL for claim.
* I will get claim number and reference number.

**If referral# is available :**

* May I know the denial.
* Can I get denied date.
* May I know who is PCP for this patient.
* I verified in system I have a referral number for this DOS can you please verify whether it is valid or not.
* (if it is valid )
* Can you reprocess the claim.
* May I know how many days it will take to reprocess the claim.
* Can I get claim number and reference number.

**If referral# is not available:**

* May I know the denial.
* Can I get the denied date.
* May I know who is the PCP for this patient.
* Can I get phone number of PCP.
* Can I send corrected claim with referral#.
* can I get fax number and mailing address.
* Can I get TFL for corrected claim .
* Can I get claim number and reference number.

|  |
| --- |
| **REFERAL# IS MENTIONED IN 23 BLOCK** |

**3 Bundle (or) Inclusive (or) Exclusive : ( Denial Code M15)**

If we file a claim for an x-ray for both right hand and left hand with an CPT code of 71020 on the same day if we file a claim for an x-ray of left hand with an cpt code 71010. We will receive this denial For this CPT code as 71010 x-ray for left hand has already included with 71020.

(Or)

Denied code payment will be included in primary CPT Code.

**Explanation to TL:**

* I will get denial.
* I will get denied date.
* I will ask to which primary CPT code it was included with.
* I will verify in system whether appropriate modifier is available or not.
* If It is already filed with appropriate modifier (I will explain to them and) I will ask them to reprocesses the claim.
* If appropriate modifier is not available on the claim. I will ask can I send an corrected claim with appropriate modifier.
* I will ask TFL for corrected claim.
* I will get claim number and reference number.

**If claim was already filed with appropriate modifier**

* May I know the denial.
* Can I get denied date.
* Can I get the line item (CPT code) which was dnd.
* May i know to which Primary cpt code it was included with.
* Hi i verified in system, Already we filed claim with appropriate modifier , can u please verify it. ( if rep said modifier is available)
* can u reprocess the claim
* may I know how many days it will take to reprocess the claim
* can i get claim# and ref#

**If claim was not filed with appropriate modifier**

* May I know the denial.
* Can I get denied date.
* Can I get the line item (CPT Code) which was dnd.
* May I know to which Primary cpt code it was included with.
* Hi can I send corrected claim with appropriate modifier.
* can I get fax number and mailing address.
* Can I get TFL for corrected claim.
* Can I get claim# and ref#.

**4 Timely Filing Limit: (**Denial Codes PI 29)

Each and Every insurance company will have a certain time period. we have to file the claim within that time period, if not we will receive this denial.

POTFL = Proof of Timely Filing Limit

**Explanation to TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will ask TFL for the claim
* I will get the claim received date.
* If it is denied incorrectly. I will ask them to reprocess the claim.
* If it is denied correctly. I will ask can I send an appeal with POTFL (Claim Sent Report Clearing House Document).
* I will get mailing address or fax number
* I will ask TFL for appeal.
* I will get claim number and reference number.
* What is the document you will use for POTFL (proof of timely filing limit)?
* Claim sent report from clearing house
* What is the TFL for Medicare?
* Medicare Tfl is 1 year

For appeals TFL is calculated from?

* Denied date.

**If claim was filed within time limit:**

* May I know the denial.
* Can I get denied date.
* Can I get received date and TFL for the claim.
* Can u please verify this claim it was denied incorrectly as we filed the claim within time limit.
* Can u reprocess the claim.
* May I know how many days it will take for reprocess the claim.
* Can I get claim# and reference number.

**If claim was filed after time limit:**

* May I know the denial.
* Can I get denied date.
* Can I get received date and TFL for the claim.
* Can I send an appeal with proof TFL.
* Can I get mailing address and fax number.
* Can I get TFL for appeal.
* Can I get claim and reference number.

**5 Primary EOB (Or) This Care May be Covered By Another Payer :**

( denial code PR 22)

If we file a claim to the secondary insurance without primary EOB then we will receive this denial.

**Explanation to TL:**

* May I know the denial .
* I will get the denied date.
* I will verify whether we have primary EOB or not.
* If we have a primary EOB, I will refile a claim to the secondary insurance with primary EOB .
* If claim was not filed to primary insurance and we are not having primary insurance details .
* I will call to secondary insurance. and I will get primary insurance details like insurance name patient ID and Mailing address.
* Then I will file the claim to primary insurance after verifying the eligibility.
* I will get claim number and reference number.

**6 Medically Not Necessary : (**Denial Code CO50)

E**xplanation to TL:**

* I will verify denial .
* I will get the denied date.
* I will ask them why it is denied as medically not necessary
* I Will ask can I submit a corrected claim with appropriate DX Code
* I Will get tfl for corrected claim
* If corrected claim is not accepted. I will ask can I send an appeal with the medical records to show the medical necessity.
* I will get mailing address or fax number (May I know whose attention it should be sent.)
* I will ask TFL for appeal.
* I will get claim number and reference number.

**If corrected claim is accepted :**

* May I know the denial .
* Can I get denied date.
* May I know the reason why claim was denied as medically not necessary .
* Can I send an corrected claim with valid DX code.
* can I get fax number and mailing address.
* Can I get TFL for the corrected claim.
* Can I claim number and reference number.

**If corrected claim is not accepted :**

* May I know the denial
* Can I get denied date
* May I know the reason why it denied as medically not necessary.
* Can I send an corrected claim with valid DX Code
* (If rep said corrected claim not accepted).
* Can I send an appeal with medical records to show medical necessity.
* Can I get mailing address and fax number.
* Can I get TFL for appeal.
* Can i get claim number and reference number.

**7 Co-Ordinate Of Benefits :**

Before taking policy patient has to update his other insurance details it is called Coordination of benefits ( COB).

(OR)

when a patient has more than one insurance plan then patient has mention which is primary and which is secondary before taking the policy.

**Explanation to TL :**

* I will verify the denial reason
* I will get the denied date .
* I will verify when patient lastly updated his co-ordination benefits .
* I will ask whether they have sent any letters to the patient or not .
* If they said they didn’t send any letter to the patient.
* I will request them to send a letter to the patient .
* If they said they already sent letter to patient .
* I will ask how many letters they have sent to patient .
* If they said they already sent three letters .
* I will ask can I bill the patient .
* I will get claim and reference number .

**If letter sent to patient :**

* May I know the denial.
* Can I get the denied date.
* May I know when patient lastly updated his co-ordination benefits.
* May I know whether you have sent any letter to the patient or not.
* (Rep we didn’t sent any letter )
* Can you please send a letter to the patient .
* Can I get claim and reference number.

**If already sent three letters :**

* May I know the denial reason.
* Can I get the denied date .
* May I know when patient lastly updated his co-ordination benefits.
* Can you please verify whether you have sent any letters to patient.
* (Rep we have 3 letters).
* Can I bill the patient.
* Can I get claim and reference number .

**8 Waiting period**

Disease which is update at the time of taking policy will not be paid for the a duration of time is called waiting period.

**If DOS is within waiting period**

* May I know the denial.
* Can I get denied date.
* Can I get waiting period.
* Can I get patient policy effective date.
* Can I bill the patient.
* Can I get claim # and reference #.

**If DOS is after waiting period**

* May I know the denial.
* Can I get denied date.
* Can I get waiting period.
* Can I get patient policy effective date.
* Can u please verify the DOS is after waiting period.
* Can u reprocess the claim.
* May I know how many days it will take to reprocess the claim.
* Can I get claim # and reference #.

**9. Non Covered Service :**

**(**DENIAL CODE NON COVER SERVICE PATIENT PLAN PR204)

(DENIAL CODE NON COVERE SERVICE PROVIDER PLAN CO 96)

If it is denied as non covered service. We have to know it is under patient plan or providers plan.

**Explanation to Tl:**

* I will get denial .
* I will get denied date.
* I will verify it is a non covered service under patient plan or provider plan.
* If they said it is under patient plan. I will ask reason why it is non covered service under patient plan.
* I will ask them can I bill the patient.
* If they said it is under providers plan. I will ask the reason why it is non covered service under provider plan.
* I will ask it is provider write-off.
* I will get claim and reference number.

**NON COVER SERVICE UNDER PATIENT PLAN**

* May I know the denial.
* Can I get denied date.
* May I know it is a non cover service under patient plan or provider plan.
* May I know the reason why it is denied as non cover service under patient plan.
* Can I bill the patient.
* Can I get claim# and ref#.

**NON COVER SERVICE UNDER PROVIDER PLAN**

* May I know the denial.
* Can I get denied date.
* May I know it is a non cover service under patient plan or provider plan.
* May I know the reason why it is denied as non cover service under Provider plan.
* Can I send an appeal with Medical Records.
* can I get fax number and mailing address.
* Can I get TFL for Appeal.
* can I get claim# and ref#

**IN YOUR PREVIOUS OFFICE FOR NON COVER SERVICES YOU WILL TAKE ADJUSTMENT?**

**I WILL FORWARD THIS CLAIM FOR CLIENT FOR ADJUSTMENT**

**10 Coverage Terminated OR** (EXPENSES INCURRED BEFOR COVERAGE TERMINATED)

If the patient plan expires before DOS, we will receive this denial.

**Explanation to TL:**

* I will get denial .
* I will get denied date.
* I will get patient policy effective date and terminate date.
* I will verify the policy coverage.
* If it is denied incorrectly. I will ask them to reprocess the claim.
* If it is denied correctly.
* I Will ask patient other insurance details
* If no other insurance details found I will ask can I bill the patient.
* I will get claim and reference number.

If patient is listed in Medicaid Insurance and we receive denial coverage terminated what u will do for this claims?

I Will not bill this patient I will forward this claim for client assistance

Reason?

Medicaid insurance people are poor people

**Patient is having coverage for this DOS**

* May I know the denial.
* Can I get denied date.
* Can I get the patient policy effective date and termination date.
* Can u please verify this claim was dnd incorrectly as patient is having coverage .
* Can u reprocess the claim.
* May I know how many days it will take to reprocess the claim .
* Can I get claim# and ref# .

**Patient is not having coverage for this DOS**

* May I know the denial.
* Can I get denied date.
* Can I get the patient policy effective date and termination date.
* May I know patient is having Secondary Insurance active for this dos.

(If rep said no active secondary insurance )

* Can I bill the patient.
* Can I get claim# and ref# .

**11 .GLOBAL:**

Certain post-operative services will not paid for a duration of time stating that it was included in previously paid surgery date of services. It is called global.

**Explanation to TL:**

* I will get the denial reason.
* I will get denied date.
* I will verify previously paid surgery DOS and CPT code
* I will get global period.(Golbal period means post operative services will not paid for a duration of time)
* I will verify DX code with surgery DOS and Denied DOS.
* If Denied DOS and Surgery DOS has different DX code. I will ask can I send an corrected claim with an appropriate modifier.
* I will ask TFL for corrected claim.
* If Denied DOS and Surgery DOS has same dx code. I will forward this claim for my client assistance for adjustment.
* I will get claim number and reference number.

**Corrected Claim**

* May I know the denial .
* Can I get denied date. May I know the surgery dos and CPT code it was included with .
* Can I get global period .
* Can I submit a corrected claim .
* can I get fax number and mailing address.
* Can I get tfl for corrected claim .
* Can I get claim and reference number.  
  (need to forward these claims for coding team for appropriate modifier)

**ADJUSTMENT CLAIM**

* May I know the denial .
* Can I get denied date?
* May I know the surgery dos and cpt code it was included with
* Can I get global period .

Can I get claim number and reference number.   
 ( need to forward these claims for client assistance for adjustments)

**12 Maximum Benefits Met:**

If the patient completed max benefits. If we file a claim after the benefits exceeded. We will receive this denial.

**Explanation to TL:**

* I will get the denial reason.
* I will get the denied date.
* I will ask them patient is enrolled in dollars plan or visits plan.
* If it is under dollars plan. I will ask them for a calendar year how many dollars is allowed for this patient
* If it is under visits plan. I will ask them for a calendar year how many visits is allowed for this patient.
* I will ask them for which DOS patient has completed his maximum benefits.
* I will ask Can I bill the patient.
* I will get claim and reference number.

**IF IT IS DOLLARS LIMIT**

* May I know the denial .
* Can I get denied date .
* May I know patient is enrolled in dollar plan or visit plan
* may I know for a calendar year for how many dollars Is allowed for this patient
* May I know for which DOS patient has completed his maximum benefits.
* Can I bill the patient.
* Can I get claim and reference number.

**IF IT IS UNDER VISITS LIMIT**

* May I know the denial .
* Can I get denied date.
* May I know patient is enrolled in dollar plan or visit plan
* May I know for a calendar year for how many visits patient is allowed .
* May I know for which DOS patient has completed his maximum benefits.
* Can I bill the patient.

Can I get claim and reference number.

**13 Duplicate: ( DENIAL CODE OA18)**

If two claims submitted to insurance and both claims having same DOS and CPT code then we will receive this denial. We have to verify whether denied it is correctly denied or not.

**Explanation to TL:**

* I will get denial reason.
* I will get denied date.
* I will ask to which claim it was referred as dupicate.
* I will verify the denied claim and original claim.
* If both claims having same DOS,CPT code, DX code ,Provider Name and Billed Amount.
* If it is denied correctly. I will ask the status of the original claim.
* If original claim and denied claim both are different.
* I will ask to reprocess the claim by explaining the difference.
* I will get claim and reference number.

**IF DND CORRECTLY**

* May I know the denial.
* Can I get denied date.
* May I know to which claim it was referred as duplicate .
* Can I get the original claim cpt code, dx code, billed amount and provider name . ( can u please wait for me for two minutes )
* can i get the status of the original claim (follow according to scenario rep said)
* can I get claim# and ref#

**IF DND IN-CORRECTLY**

* May I know the denial .
* Can I get denied date.
* May i know to which claim it was referred as duplicate .
* Can i get the original claim cpt code, dx code, billed amount and provider name.

(Can u please wait for me for two minutes) (thank u very much for waiting)

* for this patient treatment was performed twice so we have submitted claim twice can u please verify the provider name is different on dnd claim and paid claim

(rep verified provider is different )

* can u please reprocess the claim
* may I know how many days need to reprocess the claim
* Can I get claim# and ref#.

**14 Out Of Network Provider:**

If the provider is not having agreement with insurance company then the provider will be consider as out of network provider.

**Explanation to TL:**

* I will get denial reason.
* I will get denied date.
* I will verify the date from when provider is out of network.
* I will verify whether patient is having out of network benefits or not.
* If the patient is not having out of network benefits. I will ask can I bill the patient.
* If the patient is having out of network benefits , I will ask them to reprocess the claim.
* I will get the claim and reference number.

**Patient is having out of network benefits**

* May I know the denial reason.
* Can I get denied date.
* Can I get the date from when provider is out of network.
* Can u please verify patient is having out of network benefits or not .

(rep patient having benefits)

* Can u reprocess the claim .
* May I know how many days it will take to reprocess the claim .
* Can I get claim# and ref#

**Patient is not having out of network benefits**

* May I know the denial .
* Can I get denied date.
* Can I get the date from when provider is out of network .
* Can u please verify patient is having out of network benefits or not .

(rep patient is not having benefits)

* Can I bill the patient .
* Can I get claim# and ref# .

**15 CPT code incorrect for DX code :**

* I will verify denial reason.
* I will get the denied date.
* I will verify CPT code and DX code with Rep.
* I will ask the reason why CPT code is incorrect for DX code.
* I will ask them can I refile the corrected claim with appropriate CPT code .
* I will ask TFL for corrected claim.
* I will get claim number and reference number .

**1st scenario CPT code is incorrect :**

* May I know the denial .
* Can I get denied date.
* Can you tell me the denied cpt code which is incorrect for DX code.
* May I know the reason why CPT Code is incorrect for DX code.
* Can I submit a corrected claim with appropriate CPT code.
* Can I get TFL for corrected claim.
* Can I get claim and reference number .

**16 Modifier Is Inconsistent With CPT code :**

**Explanation to TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will verify CPT code and modifier with REP.
* I will ask the reason why modifier is incorrect for CPT code .
* I ask them can I refile the corrected claim with the appropriate modifier.
* I will ask TFL for corrected claim .
* I will get claim number and reference number.

**1st scenario CPT code is incorrect :**

* May I know the reason why claim was denied
* Can I get denied date.
* Can you verify modifier which is incorrect for CPT code.
* May I know the reason why the modifier is incorrect for CPT code.
* Can I submit a corrected claim with appropriate modifier.
* Can I get TFL for corrected claim.
* Can I get claim and reference number .

**17 CPT code Exceeded No of Units:**

* I will get the denial reason.
* I will get the denied date.
* I will ask for a day how many units are allowed for denied CPT code.
* I will ask them can I send an appeal with medical records.
* I will ask TFL for appeal.
* I will get mailing address OR fax number( I will ask to whose attention it should be sent )
* I will get claim and reference number.

**18. Primary Paid Maximum Or Primary Paid More than Secondary Allowed Amount:**

If primary insurance paid more than the secondary insurance allowed amount then we will receive this denial.

**Explanation to TL:**

* I will verify the denial reason.
* I will get the denied date.
* I will verify primary insurance paid amount in primary insurance eob
* I will verify secondary insurance allowed amount in secondary insurance fee schedule
* If primary paid more than secondary I will adjust the claim

**19. DIAGNOSIS CODE INCORRECT FOR CPT CODE**

**IF DX code is incorrect :**

* May I know the denial
* Can I get denied date.
* Can you tell me the denied DX code which is incorrect for CPT code.
* May I know the reason why DX Code is incorrect for CPT code.
* Can I submit a corrected claim with appropriate DX code.
* Can I get TFL for corrected claim.
* Can I get claim and reference number .

1. **Patient is in Hospice**

* May I know the denial.
* Can I get claim received date
* Can I get denied date.
* Can I get date from when the patient was in hospice.
* Can I get hospice details like hospice name, mailing address, telephone number.
* I will forward this claim to coding to add hospice modifier after that to refile the claim to hospice payer.
* Can I get claim # and reference #.

**NON DENIALS**

**NON - DENIAL MANAGEMENT:**

Basics there are several non-denials as follows below:

* **Offset**
* **Capitation**
* **Deductible**
* **Claim Paid**
* **Claim in Process**
* **Claim not found**

**1 Offset:**

It is a simple adjustment against over payment done by insurance company from one patient account to another patient account.

* I will get claim processed date.
* I will get the reason why claim was not paid.
* I will ask what is the allowed amount for this DOS.
* I will ask is there any patient responsibility or not.
* I will ask how much is applied for offset.
* I will ask to which patient DOS it was applied as offset.
* I will get that patient.
* I will get the date when they paid and I will get the check number.
* I will request EOB.
* I will get claim and reference number.

**2 Capitation:**

Provider will be received a bulk amount and will be having an agreement with the insurance company for certain period of time it is called capitation. (For that time insurance company will not pay for a provider for his service to the patient who insured in the company.)

* May I know claim processed date.
* May I know the allowed amount for this DOS.
* May I know is there any patient responsibility.
* Can I get the date from when the provider under capitation.

Can I get claim and reference number.

**3 DEDUCTIBLE:**

The amount fixed by the insurance that patient has to satisfy after satisfying this amount insurance will pay for this medical benefits.

* Can I get claim processed date
* May I know it is processed towards Innetwork or Out of network
* Can I get patient annual deductible amount.
* Can I get the allowed amount.
* May I know How much amount is applied towards deductible.
* May I know how much patient has met for this DOS
* Can I get cl # and ref #.

**4 CLAIM PAID:**

* I will ask the date when the claim was paid
* I will ask what is allowed amount
* I will ask what is the paid amount and patient responsibility.
* I will ask in which mode it was paid.
* If they said it was paid through check. I will get check number and I will get the date when it was issued.
* I will ask whether it is single check or bulk check.
* I will get check sent address.
* If they said it was paid through EFT. I will get EFT number and I will get the date when the transcation was done.
* I will ask whether it is a single transcation or bulk transcation.
* I will request EOB.
* I will get claim and reference number.

**PAID THRU CHEQUE:**

* Can I get the date when the claim was paid
* Can I get allowed amount
* Can I get the paid amount and patient responsibility.
* May I know in which mode it was paid.
* Can I get check number and can I get the date when it was issued.
* May I know it is single check or bulk check.
* (If it is Bulk check means) Can I get Bulk Amount.
* May I know check is cashed or not.
* (If cashed means) Can I get Check cashed date.
* Can I get check sent address.
* (Paid date is after 30 days means) Can you send me copy of EOB to Fax# or mealing address.
* Can I get claim and reference number.

**PAID THRU EFT:**

* Can I get the date when the claim was paid
* Can I get allowed amount
* Can I get the paid amount and patient responsibility.
* May I know in which mode it was paid.
* Can I get EFT number and can I get the date when it was issued.
* May I know it is single EFT or bulk EFT.
* (Paid date is after 30 days means) Can you send me copy of EOB to Fax# or mealing address.
* Can I get claim and reference number.

**Claim Paid to Patient**

* Can I get claim received date
* Can I get claim paid date.
* Can I get allowed amount.
* Can I get paid amount & patient responsibility.
* May I know the reason why the claim was paid to patient.
* Can I get mode of payment to patient.
* Can I get cheque or EFT number.
* Can I bill the patient.
* Can I get claim # and reference #.

**1.IF PAID DATE IS MORE THAN 30 DAYS WE HAVE TO REQUEST EOB**

**TO OUR FAX# OR BILLING ADDRESS**

**2. IF IT IS PAID THRU CHK AND PAID DATE IS MORE THAN 30 DAYS NEED TO REQUEST CASHED DATEB**

**3. IF REP IS NOT HAVING CASHED DATE NEED TO REQUEST CHK TRACER.**

**5 Claim in process**

* Can I get claim received date
* May I know normal processing time
* Can I get claim# and ref#

**6 Claim not found Or Claim Not On File (CNOF)**

* Can I get get patient policy effective date and termination date
* Can I resubmit the Claim
* Can I get TFL for claim
* Can I get electronic payor id
* Can I get mailing address
* Can I get Call ref #.