



REPRESENTING
ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

Medical Provider Informational Memorandum

Attention: All Medical Providers

The Department of Financial Services (DFS) reviews health claim payment delays pursuant to Florida Statute Sections 627.6131 and 641.3155. A summary of the timeline required is included. Claims not paid or denied by the health insurance plan or Health Maintenance Organization (HMO) in accordance with the above Florida laws should be submitted to us with written proof the claims in question have been received by the insurance plan. Please complete the attached Medical Provider Request for Assistance form and include the requested documentation listed on the form, for our review. We realize we are only requesting five (5) of your outstanding claims; however, we believe a sample of five (5) will assist us in determining a routine business practice. If necessary, we will request additional claims from you. Please do not submit personal medical records.

Under Florida Statute 408.7057, claims that involve a dispute regarding whether payment should be made, or the amount of a payment, should be referred to the Statewide Provider and Health Plan Claim Dispute Resolution Program (Maximus). Currently, the Agency for Health Care Administration has contracted with Maximus to administer this program. You may obtain information regarding their claim dispute resolution process by calling 1-866-763-6395 then chose option 5.

The DFS does not have authority over the following contracts:

- 1) Contracts purchased in a State other than Florida,
- 2) Self-insured Federal Government employee contracts,
- 3) Self-insured Employee Welfare Benefit Plan established under the Employee Retirement Income Security Act (ERISA),
- 4) and, **Prepaid** Dental claims (contractual)

Listed below are other agencies that handle various health insurance disputes.

Disputes involving a Medicare Health Maintenance Organization (HMO), Medicare Preferred Provider Organization (PPO), Medicare Private Fee-For-Service (PFFS), or Medicare Provider Sponsored Organization (PSO), and Medicare Part D (prescription coverage) should be filed directly with the:

Centers for Medicare and Medicaid Services,
Division of Medicare,
61 Forsyth Street #4T20
Atlanta, Georgia 30303-8909
Telephone Number: (404) 562-7500

Disputes involving a Medicaid HMO, the complaint should be filed directly with the:

Agency for Health Care Administration
Bureau of Managed Health Care
2727 Mahan Drive, Building 1, Mail Stop 26
Tallahassee, Florida 32308
Telephone Number: 1 (888) 419-3456
(In addition, DFS does not have authority over the Federal Medicaid Program)

Complaints involving a commercial HMO and a denial of service, pre-existing condition(s), non-emergency, etc., will not be addressed through this process. In those cases, the patient must file a grievance with his/her HMO. The instructions for filing a grievance will be found in their contract with the HMO. The HMO has 60 days to respond to the grievance. If after 60 days the problem has not been resolved, the patient can appeal to the Subscriber Assistance Program. For additional information, please call the Agency for Healthcare Administration toll-free at 1-888-419-3456.

Disputes involving Self-insured Non-Governmental Plans should be referred to the:

U.S. Department of Labor*
Employee Benefit Security Administration
8040 Peters Road, Bldg. H, Suite 104
Plantation, FL 33324
Toll Free Helpline: 1-866-275-7922 or Direct: 954-424-4022

* NOTE: As per the U.S. Department of Labor, complaints must be filed by the patient/insured or his/her legal representative).

Disputes involving Federal Employee Plans should be referred to the:

U.S. Office of Personnel Management
Federal Employee Health Benefit Programs
Insurance Review Division, #1
1900 E. Street NW
Washington, DC 20415-3500
Telephone Number: (202) 606-0727

Disputes involving Tricare (Military) Claims should be referred to the:

Palmetto Government Benefits Administration
Tricare Claims Department
PO Box 7031
Camden, SC 29020-7031
Toll Free Number: 1-800-403-3950 South Region or
Website Address: www.tricare.osd.mil

If you have additional questions, you may call our Consumer Helpline at 1-877-693-5236 within Florida or (850) 413-3089 outside of Florida between 7:00 a.m. and 6:00 p.m. Monday through Friday. An Insurance Specialist will be happy to answer your questions.

Processing Provider Claims in a Timely Manner

Below is the summary of time frames health insurance companies and Health Maintenance Organizations (HMOs) must follow to pay and/or address claims in a timely manner, pursuant to Florida Statute Chapters 627.6131 and 641.3155. If the medical provider claims are not being handled according to this timeline, the Florida Department of Financial Services can review your claim(s) for compliance.

All Electronically Submitted Claims:

A health insurer must acknowledge receipt of an electronic filed claim **within 24 hours** after receipt of the claim.

Within 20 days after receipt of the claim, a health insurer must pay or notify the provider or designee if a claim is denied or contested.

A provider must submit additional information regarding the denied or contested claim **within 35 days** after receipt of the notification.

An insurer must pay or deny a claim **within 90 days** after receipt of the claim. Failure to pay or deny a **claim within 120 days** after receipt of claim creates an uncontestable obligation to pay the claim.

Non-electronically Submitted Claims:

A health insurer must acknowledge receipt of the claim **within 15 days** after receipt of the claim.

Within 40 days after receipt of the claim, a health insurer must pay the claim or notify a provider or designee if a claim is denied or contested.

A provider must submit additional information or documentation **within 35 days** after receipt of the notification.

A claim must be paid or denied **within 120 days** after receipt of the claim. Failure to pay or deny a **claim within 140 days** after receipt creates an uncontestable obligation to pay the claim.

An overdue payment of a claim bears simple interest of 12 percent per year on claims. (Proof of receipt by the insurance carrier or HMO must be provided.)

MEDICAL PROVIDER REQUEST FOR ASSISTANCE

**PLEASE TYPE OR WRITE CLEARLY
and
Follow the Instructions Listed Below:**

- ✓ **Please limit additional documentation and only include information, correspondence, or other papers that are instrumental in the processing of your request.**
- ✓ **Please do not submit personal medical records.**
- ✓ **PROVIDE A COPY OF EACH INSURED'S IDENTIFICATION CARD (front and back).**
- ✓ **PROVIDE PROOF OF CLAIM RECEIPT BY INSURER.**
- ✓ **Please submit five (5) claims per company.**

- ✓ **Provide DFS's Service Request Number, if previously provided
SR# _____**

Insurance Company or HMO (Full Name): _____

Name of the Provider (Group): _____

Provider Contact Person: _____

Provider Complete Mailing Address: _____

Provider Telephone Number: ()- -

(1) Name of Insured: _____

Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

(2) Name of Insured: _____

Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

Medical Provider Request For Assistance Form (cont'd.)

(3) Name of Insured: _____
Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

(4) Name of Insured: _____
Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: \$ _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

(5) Name of Insured: _____
Name of Patient: _____

Insured's Complete Mailing Address: _____

Policy Number/ Claim Number: _____ Group Name and Number: _____

Date Claim Received by Company: _____ Amount Due: _____

*Electronically: _____ Date(s) of Service: _____

*Non-electronic: _____ / /

Please return completed form(s) to: **Department of Financial Services**
Attn: Medical Provider Section
Bureau of Consumer Assistance
200 E. Gaines Street
Tallahassee, FL 32399-0322