

Medicaid Clean Claim Report

You may file this report for an individual claim if it is a payable clean claim.

It must be filed electronically with an HMO for a Medicaid-covered service for a Medicaid member.

Provider Name		
Provider Address		
City	State	Zip
HMO Name		
Member Name		

Provider Tax ID number (FEIN)									
Provider's HMO Plan ID Number									
Member's HMO ID number (Not member's Medicaid ID)									
Procedure Code									
ICD-9-CM Diagnosis Code									
Authorization No. (if required by HMO for particular service)									

Important Note: Format all dates as MM/DD/YY

Date of Service						Date Provider billed Plan					

1. Did Provider have proper plan authorization (including authorization number) at the time of service, if required? Yes No NA
2. Did Provider use a clearinghouse to check for completeness of claim form? Yes No
3. Did Provider verify plan membership of patient at time of service? Yes No
4. Did Provider verify Primary Care Provider (PCP) status at the time of service? Yes No NA
5. Did HMO communicate any denial of your request for payment? *If Yes, proceed to 6. If No, complete 5A and skip to 7.* Yes No

5A. If HMO did not respond to the request for payment, describe any proof you have that claim was received by the HMO:

6. Reason given by HMO for denial of payment: *Explain in words. Do not use Plan rejection codes!*

6A. Date of 1 st Denial by HMO					

7. Was a second denial received? Yes No 7A. If yes, was corrected information given? Yes No

7B. Reason given by HMO for 2nd denial of payment:

7C. Date 2 nd claim submitted					

7D. Date of 2 nd Denial by HMO					

8. Have you discussed this claim with HMO staff? Yes No

8A. If yes, what was the Plan's explanation (if any) for the claim rejection?

9. Have you requested arbitration of this claim as permitted under the HMO contract Administered by the Medical Services Admin., Dept. of Health & Human Services (Medicaid)? Yes No

Attach any additional information that provides facts or proof that will assist us in settlement of this claim. Any such attachments are subject to the above certification of Provider or representative. Always send photocopies. Never send original documents.

Certification: I certify that this information is complete and correct. I have followed the requirements of Public Act 187 of 2000. This claim is a payable clean claim that met all required timelines for claims submission under the act.

Signature of Provider or representative	Date signed	Contact person name and title (or check if <input type="checkbox"/> same as signer)
Above signer's name and title typed or printed		Phone Number: _____
		Fax Number: _____
		Email: _____

When report is complete,

Fax to: 517-284-8838

or return by mail to:
DIFS – Office of Appeals, Legal Research, and Market Regulation
PO Box 30220
Lansing, MI 48909-7720

or by delivery service to:
DIFS – Office of Appeals, Legal Research, and Market Regulation
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

or by email to:
DIFS-HealthAppeal@michigan.gov

PA 187 of 2000 as amended requires submission of this form by any provider seeking relief for clean claims not paid in a timely manner as described in the act.



Michigan Department of Insurance and Financial Services

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