FIS 0278 (4/20) Department of Insurance and Financial Services

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 1st Denial by HMO

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

7C. Date 2nd claim submitted

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

_____

_____

7D. Date of 2nd 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

Above signer's name and title typed or printed

Contact person name and title *(or check if ☐ same as signer)*

Phone Number: _____

Fax Number: _____

Email: _____

When report is complete,

Fax to: 517-284-8838

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

or by delivery service to:
DIFS – Office of Research, Rules, and Appeals
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.