

## Reportable Medicaid Claims

1. Report may be based on Medicaid Claims OR Medicaid Claims Lines.

Indicate the basis you are using:

- choose  Medicaid Claims  
 only one  Medicaid Claim Lines

Use same basis throughout this filing

2. Report total Medicaid claims/claim lines received in requested time period.	3. Report total number of second denied Medicaid claims/claim lines in requested time period.	4. Report second denied Medicaid claims/claim lines as a % of total claims processed in requested time period.

5. Use the formats below to prepare the Report and Summary using your information technology. Provide report in black print on 8½" x 11" white paper. Use easily readable type, such as Arial 7.5pt or larger.

Number pages of each report in this format: Page X (page number) of Y (total pages). Example: Page 1 of 3

Report Claim or Claim Line rejected a SECOND TIME. Do not report Claims/Claim Lines rejected only once!

Label columns in the order show below. Use a line for each claim or claim line with defect (rejected twice). Use at least 3 spaces or a vertical line to separate columns. Record all dates in MM-DD-YY format.

REPORT FORMAT: Please sort report in ascending order based on Provider Federal Employer ID (FEIN). Number pages as Page X (page number) of Y (total pages of report).

QHP Claim Identifier	Provider name	Provider type code	Provider's Federal Employer ID (FEIN)	Date of Service	Date claim was received	Date claim rejection notice sent to provider	Rejection code (FIRST rejection)	Date SECOND claim was received	Date SECOND claim rejection notice sent to provider	Rejection code (SECOND rejection)
S123456	SampleClinic	XX	22222222	02-13-22	03-13-22	04-13-22	123456	05-13-22	06-13-22	654321

Each reported claim should look similar to this example

SUMMARY FORMAT: Label columns as shown below to prepare a Summary by Rejection Code. Number pages as Page X (page number) of Y (total pages of summary). Please sort summary by "Second denied Medicaid claims as a percentage of total..." (last column) in descending order (highest percentage first, lowest percentage last)

Rejection Code	Description of rejection code	Number of Medicaid claims denied a second time in report period	Second denied Medicaid claims as a percentage of total second denied claims for report period
MEMNEL	Member not eligible at date of service	29	4.27%

Each line should look similar to this example



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This form relates to HMOs that provide Medicaid services.

### DUE ONLY UPON REQUEST

6. HMO:

7. REQUESTED TIME PERIOD:

Public Act 187 of 2000 amends the Social Welfare Act (Public Act 280 of 1939) to add requirements for timely payments to providers for covered health care services rendered to persons enrolled in Medicaid who are members of a qualified health plan (QHP). MCL 400.111(2)(i) requires that a qualified health plan notify the health professional or facility and the director of a defect in a claim if it is not payable the second time it has been submitted, regardless of the reason.

8. Certification:

I certify that I have thoroughly examined this report. The information contained in and attached to it is complete and correct to the best of my knowledge and belief.

Signature of HMO's authorized representative | Date signed

Signer's name and title (please type or print)

Contact person's name and phonenumber (include area code)

( )

Contact person's Email address

9. When this form is complete, attach report and summary.

Completed forms and additional information (if applicable) should be submitted to DIFS, Office of Insurance Rates & Forms, P.O. Box 30220, Lansing, MI 48909-7720.

Any questions, please call 517-284-8715