FIS 0284 (12/23) Department of Insurance and Financial Services

Clean Claim Report

You may file this report for an individual claim if it is a payable clean claim. It must be a claim filed with a Health Care Plan for a covered service.

If claim meets each of these conditions, continue.
If claim does not meet each condition, you may not file this report.

Provider Name

Provider Address

City **State** **Zip**

Health Care Plan Name

Member Name

Provider Tax ID number (FEIN)	
Provider's Plan ID Number	
Member's ID number (Not member's Medicaid ID)	
Procedure Code	
ICD-9-CM Diagnosis Code	
Authorization No. (if required 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 if required? ☐ Yes ☐ No ☐ NA

5. Did Health Care Plan communicate any denial of your request for payment? *If Yes, skip 5A. If No, complete 5A and skip to 7.* ☐ Yes ☐ No

5A. *If Health Care Plan did not respond to the request for payment, describe any proof you have that they received the claim:*

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

6A. Date of 1st denial by plan

7. Was a second denial received? ☐ Yes ☐ No

7C. Date 2nd claim submitted

7A. If yes, was corrected information given? ☐ Yes ☐ No

7B. Reason given by *Health Care Plan* for 2nd denial of payment:

7D. Date of 2nd denial by plan

8. Have you discussed this claim with Health Care Plan staff? ☐ Yes ☐ No

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

9. Did you send a copy of this report to the Health Care Plan? ☐ Yes ☐ No

If Yes, complete **9A**. If No, your clean claim report processing will be delayed.

9A. Date of notification

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 316 of 2002. 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:: _____

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.

MCL 500.2006 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.

When report is complete:

Fax to: 517-284-8838

Return by mail to: **OR** *By delivery service:*

DIFS - OALRMR
PO Box 30220
Lansing, MI 48909-7720

DIFS - OALRMR
530 W. Allegan St, 7th Fl.
Lansing, MI 48933

Email: DIFS-HealthAppeal@michigan.gov

Michigan Department of Insurance and Financial Services

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