

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	Signer's name and title typed or printed

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.



Michigan Department of Insurance and Financial Services

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