

TO: Maryland Insurance Administration
Attn: _____ Unit
525 St. Paul Place
Baltimore, MD 21202-2272



SEMI-ANNUAL CLAIMS DATA FILING FORM

(Check one and complete for reporting period)

_____ September 1, 20____, for claims received for the period of January 1 – June 30, of the same calendar year	_____ March 1, 20____, for claims received for the period of July 1 – December 31 of the preceding calendar year
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(Check one for reporting period)

_____ Clean Claims data reported below is based on claims containing <u>all</u> of the essential data elements required by COMAR 31.10.11.	_____ Clean Claims data reported below is based on claims containing <u>fewer than all</u> of the essential data elements required by COMAR 31.10.11. <i>(Complete Attachment A.)</i>
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Part I. Clean Claims *(HCFA 1500 & UB92 only)*

- A. Total number of Clean Claims received: _____
- B. Total number of claims denied because necessary data elements of Clean Claim not received: _____
- C. Number of claims denied:
 - (1) Because HCFA 1500/UB 92 Form data incomplete or missing: _____
 - (2) Because attachment incomplete or missing: _____

Part II. Claims Adjudication *(Applies to all claims)*

All Claims

- A. Total number of all claims received: _____
- B. Number of claims paid (includes partially paid): _____
- C. Number of claims denied payment: _____
- D. Number of claims denied payment based on the following five most prevalent reasons:
(Use exact denial reason code explanations or submit text on Attachment B.)
 - (1) _____
 - (2) _____
 - (3) _____
 - (4) _____
 - (5) _____

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Part III. Claims Inventory *(Applies to all claims)*

All Claims

- A. Beginning inventory at start of report period: _____
- B. Number of claims pending for legitimate dispute/
additional information at end of report period: _____
- C. Number of claims received but not yet processed
as of last day of report period: _____
- D. Ending inventory at end of report period _____

Part IV. Prompt Payment *(Applies to all claims)*

(Time frames are calculated from the date a payor receives a clean claim, or additional information pursuant to a legitimate dispute is received, to the date the claim is adjudicated.)

	<u>Number</u>	<u>Dollar Amount Paid</u>	<u>Interest</u>
<u>Claims adjudicated in</u>			
A. 30 days or less	_____	_____	<u>N/A</u>
B. 31-60 days	_____	_____	_____
C. Over 60 days	_____	_____	_____
D. Total	_____	_____	_____

Part V. Payor Information

Payor Name	NAIC Number
Delegated Agent (Yes/No)	Processing Claims on Behalf of
Payor Address (line 1)	
Payor Address (line 2)	
City/State/Zip Code	
Payor Contact Person (Please print)	Phone Number
Signature of Contact Person	Date Submitted

Signer certifies that the information submitted on this form and its attachments is correct and accurately represents the claims filing and processing activity of the Payor for the reporting period indicated.

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ATTACHMENT B

Payor Name: _____

Following is the exact denial reason code explanation text for the five most prevalent reasons claims are denied payment by our organization as reported on the SEMI-ANNUAL CLAIMS DATA FILING FORM:

1.

2.

3.

4.

5.
