

## **Policy 1230**

### **NHP/NHIC ~ Timely Filing Guidelines**

**Purpose:** This policy is to provide guidelines for Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) timely filing requirements.

**ANSI Code Denial:** 29 ~ The time limit for filing has expired.

**Policy and Procedure:** The initial submission of a claim is subject to the Timely Filing Guidelines outlined in your Provider Contract with NHP/NHIC.

NHP/NHIC will only accept written claims submitted in the English language. Claims must be submitted within 365 days after the date of service, no exceptions. When NHP/NHIC is the secondary payor, claims must be submitted to NHP/NHIC within 365 days after the date of processing listed on the primary payor's Explanation of Benefits (EOB) or as listed in your Provider Contract, no exceptions. When a provider's electronic claims are received in our Claims Department, NHP/NHIC will provide proof of receipt to the submitting provider via the Electronic Claims Confirmation Report, or the Rejected Claims Report.

If a claim is rejected for improper EDI submission, resubmission must be completed by the provider within the filing limit as outlined above. Resubmissions and/or corrections can be made by the provider directly on the Rejected Claims Report or on the Remittance Advice received.

All resubmissions and/or corrections should be submitted on a paper claim and clearly identified. Please indicate by using a modifier CC next to the corrected CPT/HCPC's code or note "corrected claim" on the form. This will prevent a provider's claim(s) from being denied as a duplicate submission. Claim resubmissions should be sent to Network Health Plan/Network Health Insurance Corporation, P.O. Box 568, Menasha, WI 54952.

Please be aware that when a provider fails to submit a claim timely, rights to payment from NHP/NHIC are forfeited and the provider may not seek payment from the member as compensation for these covered services.

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**This policy is not a guarantee of coverage or payment. The claim(s) will be denied if it does not meet with all the terms and provisions of the members Certificate of Coverage. Actual benefits will be determined when the claim(s) or bill(s) are submitted to NHP/NHIC. NHP/NHIC reserves the right to periodically review and update all claims policies and procedures.**

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