

Bluegrass **Family Health**

Timely Filing of Claims

Claims must be submitted to BFH within one-hundred eighty (180) days or within the timeframe outlined in the Provider Participation Agreement. If a Provider chooses to inquire about a claim that has been denied for exceeding the filing limit (NCTF), proof of timely filing must accompany the request. This proof must be submitted within one year of the dates of service/discharge and come in the form of one of the following:

- Computer screen print showing the claim was filed to BFH within one-hundred eighty (180) days of the date of service or date of discharge.
- Certified Mail receipt providing that the claim(s) were received by BFH within one-hundred eighty (180) days of the date of service or date of discharge.

If this proof can be provided, the claim(s) will be reprocessed.

Exceptions to the timely filing rule, which will be reviewed on a case-by-case basis, include:

- When COB/Subrogation is involved, the claim and primary insurer's remittance advice must be filed within twelve (12) months of the primary insurer's remittance date.
- When the Member does not present accurate insurance information until after the filing deadline, the Provider must be able to provide evidence of routine billing to the Member within the lapsed timeframe. The Provider must bill the claim within thirty (30) days of receiving the insurance information from the Member. This must be proven through computer or account records.

Filing Corrected Claims

All corrected claims must be filed within the timely filing guidelines or within thirty (30) days from the date of the Remittance Advice showing the processed claim, if the filing limit has expired.