

Claims Documentation Requirements

Understanding what's an acceptable form of documentation really just comes down to five key details: Who, What, When, Where and How Much. When you submit your claim for reimbursement, look at your documentation and confirm that it includes all the necessary pieces. If it doesn't, your reimbursement may be delayed or denied (and no one wants that!). The good news is, most documentation you receive from pharmacies or medical providers includes everything that's needed!



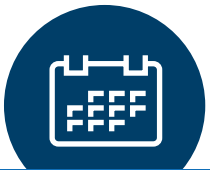
WHO

This is the name of the patient or, in the case of insurance premiums, the name of the insured person. This could be you, your spouse or an eligible dependent. Ultimately, to protect your benefit funds, we need to see who the medical expense is for.



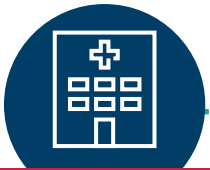
WHAT

What is the medical expense? Is it an annual check-up, a prescription refill or an insurance premium? Your documentation should include a description of exactly what type of medical expense you're submitting for reimbursement.



WHEN

There should be a service date on the documentation you provide. This could be the date of medical service, the date your prescription was filled, or the coverage period for your insurance.



WHERE

Where did you receive medical treatment? Where was your prescription refilled? The name of the provider or pharmacy should appear somewhere within your documentation. For premiums, make sure the name of the insurance carrier is also included.



HOW MUCH

How much did the medical expense cost? Your documentation should always include the cost of the service, item or premium you're submitting for reimbursement.

Examples of Good Documentation



Medical Services

FORWARD SERVICE REQUESTED

For Billing Inquiries Call:
Sample Medical Care Provider
 (800) 000-0000

Sample Participant
 1234 ABC Street
 Somewhere, State 12345

Messages:
 • PAYMENT DUE DATE: 30 DAYS FROM THE STATEMENT DATE
 • You may now access your account online

Statement Detail Statement Date: 2017-12-17 Account No. 1234

Claim No.	Visit Date	Activity Date	Description of Service	Charges	Payments	Balance
12345	2017-01-01	2017-01-01	8297 Sample Testing	150.00		
12345	2017-01-01	2017-01-01	8237 Sample Testing	75.00		
12345	2017-01-01	2017-01-01	2347 Sample Testing	207.00		
12345	2017-01-01	2017-01-01	Patient Payment		45.00	
12345	2017-01-01	2017-01-01	Sample Insurance Payment		150.00	
12345	2017-01-01	2017-01-01	Sample Insurance Adjustment		125.00	
12345	2017-01-01	2017-01-01	Your Balance Due on These Services			112.00

Payment Due
112.00

Itemized Receipt

WHERE

WHO

WHAT

WHEN

HOW MUCH

ABC Health Insurance Company

**EXPLANATION OF BENEFITS
THIS IS NOT A BILL**

Sally Sample
 123 ABC Street
 ABC, FL 12345

Subscriber Information
 Member ID: 123456789abc
 Group ID: 123456
 Group Name: ABC Corp.

Patient Name: Sally Sample Claim Number: 012345687 Provider: ER & Hospital
 Place of Service: Outpatient Type of Service: Medical Payment to: ER & Hospital
 Date Received: MM/DD/YYYY Date Processed: MM/DD/YYYY

Date of Service	Total Charges	Amount paid by health plan	Deductible	Co-Insurance	Co-pay	Total Patient Responsibility
mm/dd/yyyy	\$100.00	\$85.00	\$0.00	\$0.00	\$15.00	\$15.00

You are responsible for **\$15.00**

Explanation of Benefits

WHO

WHERE

WHAT

WHEN

HOW MUCH

Examples of Good Documentation



Premiums

ABC Benefits Administration 7805 Benefits Blvd. Your Town, MN 98765		Invoice Invoice Date: MM/DD/YYYY Invoice: 1002500 Terms and Conditions Please review this invoice carefully and notify us of any discrepancies. As a reminder, please pay your invoice as billed. Any changes will be reflected on your next invoice. Please note, premium credits will only be allowed 90 days back from the date of this invoice. Thank you.	
Bill To: Doe, John 1234 Main Avenue Happy Valley, USA			
Make Check Payable To: ABC Benefits - Or pay online at www.abc.biz		Send Payments To: ABC Benefits Administration 7805 Benefits Blvd. Your Town MN 98765	Biller Contact: Jane Doe 800-555-XXXX
Charge Summary			
Date: MM/DD/YYYY Product: Med Adv Value BCBS Coverage: Emp + Spouse Amount: \$1,637.24 Total: \$1,637.24			
Account Statement			
Date: MM/DD/YYYY Description: Beginning Balance Amount: \$0.00 MM/DD/YYYY Standard Invoice 1002544 Amount: \$1,637.24 Ending Balance: \$1,637.24			

WHERE

WHO

HOW MUCH

WHAT

WHEN

Premium Invoice

WHERE

WHO

WHEN

WHAT

HOW MUCH

Your New Benefit Amount

BENEFICIARY'S NAME: SALLY SAMPLE

Your Social Security benefits will increase by 1.6% in YYYY because of a rise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent, or energy assistance. You can also use it to apply for bank loans or for other business. Keep this letter with your important financial records.

How Much Will I Get And When?

- Your monthly amount (before deduction) is **\$1,500.00**
- The amount we deduct for Medicare Medical Insurance is **\$140.00**
(If you did not have Medicare as of Month DD, YYYY or if someone else pays your premium, we show \$0.00)
- The amount we deduct for your Medicare Prescription Drug Plan is **\$0.00**
(We will notify you if the amount changes in YYYY. If you did not elect withholding as of Month DD, YYYY, we show \$0.00)
- The amount we deduct for voluntary Federal tax withholding is **\$0.00**
(If you did not elect voluntary tax withholding as of Month DD, YYYY, we show \$0.00)
- After we take any other deductions, you will receive **\$1,360.00** on or about Month DD, YYYY.

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. Or visit www.ssa.gov/non-medical/appeal to appeal online. We would be happy to review the amounts.

If you receive a paper check and want to switch to an electronic payment, please visit the Department of Treasury's Go Direct website at www.godirect.org online.

Award Letter

ABC Insurance ABC INSURANCE CO. 123 SAMPLE STREET CITY, STATE 12345	Important Premium Information
Sally Sample 123 ABC Street City, State, Zip <p>Dear Sally Sample:</p> <p>We would like to thank you for choosing ABC Insurance to help with your health care coverage needs.</p> <p>Effective Month DD, YYYY the monthly amount of your premium will be \$300.00. Any discounts for your premium have been applied.</p> <p>Any change in your premium does not affect your benefits. If you would like to stay with your current coverage, just continue making your premium payment.</p> <p>Thank you for your membership.</p> <p>Sincerely, ABC Insurance</p>	

WHERE

WHO

WHAT

WHEN

HOW MUCH

Premium Notice

Examples of Good Documentation



Prescriptions

WAITING TA Promised: MM/DD/YYYY PM

Sample, Sally
345 ABC Way
Tampa, FL 12345

Counsel - Prescription Schedule

Prescription Information

METOPROLOL TARTRATE 50 MG TAB
(Common brand(s) - Lopressor)

Take 1 tablet twice a day

Important Information

- Take with or immediately after food.
- Take or use this exactly as directed. Do not skip doses or discontinue.
- May cause dizziness.
- May cause drowsiness. Alcohol intensifies effect. Use care using machines.

Receipt & Refill Information

ABC Pharmacy # METOPROLOL TARTRATE 50-MG TAB

STORE TEL: 00 NDC: QTY: 60 DAIN: 0

INSURANCE INFORMATION: PAID: \$100.00 CAP: Safety

United Healthcare Bin: Tufts Health Plan

MFR: Teva USA REFILLS: 4 by 7/1/17 PRSCR: DAYS SUPPLY: 30 DATE FILLED: 5/27/15

RETAIL PRICE: \$140.99 DISCOUNT: \$10.00 TAX: \$10.00 AMOUNT DUE: \$10.00

Notes from the Pharmacy

Ask the pharmacist about your new personalized Prescription Schedule.

ABC Pharmacy OPEN HERE

Prescription Receipt

WHEN

WHO

WHAT

WHERE

HOW MUCH

Store #: 123 Report Date: MM/DD/YYYY

EFG Pharmacy System
Big-Mart Pharmacy 12-345
Medical Expense Summary

Patient: Doe, John
321 RD
Hamot, WI 12345

Birthday: MM/DD/YYYY

Below is a list of your Pharmacy Orders for the range of: MM/DD/YYYY to MM/DD/YYYY

Big-Mart Pharmacy, 123 West Lane Blvd, Hamot, WI- 12345
NABP Number: 1112223 ID: BW123456 NPI: 12345678910

Date Filled Date Written	Rx Filled ID	Drug Name NDC	Prescriber	Qty Refill #	Days Supply	Dispense As Written	Patient Paid TP Ref #
MM/DD/YYYY MM/DD/YYYY	1234567 1234567	DRUG 10MG TAB	Doe, Jane	20 0	10	0	\$ 5.00 123456789101112131415161718
MM/DD/YYYY MM/DD/YYYY	1234567 1234567	DRUG 10MG TAB	Doe, Jane	30 0	14	0	\$ 5.00 123456789101112131415161718

Report Date: MM/DD/YYYY
Attested To By: Registered Pharmacist

Total: \$ 10.00

Medical Expense Summary

WHERE

WHO

WHAT

WHEN

HOW MUCH