Insurance Covered Claims

- Providers are responsible for following the claims submission procedures of the insurance company. Failure to follow pre-certification procedures and other insurance conditions for payment may result in the claim being returned to the provider to resubmit to the insurance company.
- Providers can bill CMH for services provided to families with health insurance if the service is not covered under the policy or the insurance company has not paid the claim within 60 days of when the bill was submitted. Providers should send CMH the invoice and a rejection notice from the insurance company, or written verification of the date they billed the insurance company. For claims submitted to CMH without a rejection notice, CMH will make the payment if the insurance company has not paid after 90 days. CMH will not make payment if the insurance company was not billed properly.
- When submitting to CMH a claim that the insurance company has not paid in full, the provider should send, with the claim, a copy of the explanation of benefits (EOB) notice. The amount paid by the insurance company must be indicated in the appropriate block on the claim form.
- When the family's insurance company pays the provider more than the CMH allowable fee, CMH will issue a Remittance Advice showing the payment as **$0.00.** Because the provider received more than CMH would have paid, **the insurance payment is to be accepted as payment in full and the balance of the claim is to be written off by the provider as per the Provider Agreement.**