
Submitting Proof of Timely Filing

Timely filing denials are often upheld due to incomplete or invalid documentation submitted with reconsideration requests. The following information has been compiled to help clarify the documentation required as valid proof of timely filing documentation. When submitting a request for reconsideration of a claim to substantiate timely filing, please follow the appropriate instructions below.

For claims submitted electronically:

- Submit an electronic data interchange (EDI) acceptance report from Claimsnet. Please note that confirmation of receipt from the provider's clearing house and/or a rejection report from Claimsnet would not be acceptable.
- Note: A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.
- The acceptance report must:
 - Include the actual wording that indicates the claim was either "accepted," "received" and/or "acknowledged." (Abbreviations of those words are also acceptable.)
 - Show the claim was accepted, received and/or acknowledged within the timely filing period.

For paper claims:

- Claims (including revisions or adjustments) that are not filed prior to the claim filing limit will be denied and are the provider's liability.
- If a claim submission is rejected due to incorrect or invalid information, it is the provider's responsibility to make the necessary corrections and resubmit the claim within the timely filing period. This includes patient insurance information.
- All rejected claims should be researched, corrected and resubmitted as soon as possible, but no later than the expiration of the timely filing period.
- Read your paper claim rejection letters promptly and resubmit a new corrected claim within the timely filing period.
- Review your claim carefully before submitting. Corrected claims are not exempt from timely filing.
- Remember, you cannot bill the member for timely filing denials.

Lack of insurance information:

- Documentation that demonstrates the provider did not receive correct insurance information from the member at the time of service. Please note that AdventHealth Advantage Plans will utilize claims history from the provider to determine if prior claims were submitted by the provider.

Other insurance (Coordination of Benefits/Subrogation):

- Documentation that demonstrates that another insurance company made payment and then recouped the payment. The claim must be submitted to AdventHealth Advantage Plans within three months of the primary carrier's payment/determination.

Other valid proof of timely filing documentation:

Valid when incorrect insurance information was provided by the patient at the time the service was rendered:

- A denial/rejection letter from another insurance carrier.
- Another insurance carrier's explanation benefits.
- Letter from another insurance carrier or employer group indicating no coverage for the patient on the date of service of the claim.
- All of the above must include documentation that the claim is for the correct patient and the correct date of service.

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