Payment Policy | Timely Filing

EFFECTIVE DATE: 02|15|2011
POLICY LAST REVIEWED: 11|05|2025

OVERVIEW

This policy is to document the general requirements for the timely filing of claims by providers. Contracts may differ and supersede this information.

POLICY STATEMENT

Commercial:
Contracts may differ and supersede this information
General requirements for filing of claims for participating providers;

The filing limit for claim submission for services to Blue Cross Blue Shield of Rhode Island (BCBSRI) for commercial members is 180 days from the date of service.

- For inpatient admissions, the filing limit is 180 days from the date of discharge.
- When coordinating benefits with a primary insurance carrier, such as Medicare, the filing limit for claims submission to BCBSRI is 180 days from the date that the primary insurer processed the claim; this process date must be indicated on the primary insurer's Explanation of Benefits (EOB), and the EOB itself must be included with the claim submission.
- Members cannot be billed for services denied because the filing limit was exceeded.

Time Limits

- Filing limit appeals must be received within 60 days of the original BCBSRI Remittance Advice (**RA)** date.
- Any appeal that is received after 60 days of the BCBSRI RA denial date, will not be considered for appeal.
- Members cannot be held liable for claims denied for exceeding the appeal filing limit.

Time Limits: Corrected Claim or Claim Adjustment Request

- Other carrier EOB within 180 days of retraction
- Corrected claim within 180 days of denial disposition Corrected claim within 18 months of paid dispositions (Commercial only)
- Corrected claims should be submitted on paper or through the web application. By using the *Physician/Provider Claim Adjustment Request* ***form*** or submitting through the online application as a claim adjustment, the receipt date will update accordingly.

Note*: Use one* ***form*** *per claim to make adjustments to a claim that was previously submitted.*

Medicare Advantage Plans participating providers:
Contracts may differ and supersede this information

The filing limit for claim submission for services to Blue Cross Blue Shield of Rhode Island (BCBSRI) for Medicare Advantage Plans members is 180 days from the date of service.

- For inpatient admissions, the filing limit is 180 days from the date of discharge.
- When coordinating benefits with a primary insurance carrier, the filing limit for claims submission to BCBSRI is 180 days from the date that the primary insurer processed the claim; this process date must be indicated on the primary insurer's Explanation of Benefits (EOB), and the EOB itself must be included with the claim submission.

- Members cannot be billed for services denied because the filing limit was exceeded.

Dental Providers:

The filing limit for claim submission for services to Blue Cross Blue Shield of Rhode Island (BCBSRI) for Dental services is 365 days from the date of service.

- When coordinating benefits with a primary insurance carrier the filing limit for claims submission to BCBSRI is 365 days from the date that the primary insurer processed the claim; this process date must be indicated on the primary insurer's Explanation of Benefits (EOB), and1 the EOB itself must be included with the claim submission.
- Members cannot be billed for services denied because the filing limit was exceeded.

Nonparticipating providers or Member submitted receipts for services out of the service area (OOS) and local nonparticipating providers

The filing limit for claim submission for services to Blue Cross Blue Shield of Rhode Island (BCBSRI) members is 365 days from the date of service.

- For inpatient admissions, the filing limit is 365 days from the date of discharge.
- When coordinating benefits with a primary insurance carrier, such as Medicare, the filing limit for claims submission to BCBSRI is 365 days from the date that the primary insurer processed the claim; this process date must be indicated on the primary insurer's Explanation of Benefits (EOB), and the EOB itself must be included with the claim submission.

Veterans Administration Facilities

- Veterans Administration Facilities have a 6 year Filing Limit.
- Military Facilities have a 6 year Filing Limit.
- Indian Health Service Providers have an unlimited Filing Limit

MEDICAL CRITERIA

Not Applicable

BACKGROUND

Claims Submission and Payment

A claim must be submitted for all services not included in a capitation compensation arrangement. Claims for non-capitated services provided by personal physicians will be considered for payment of allowable fees and accumulation of utilization data related to ambulatory services.

When the rendered services are included in a personal physician's capitation arrangement, a data-only claim is submitted. These claims are called encounter claims. All mandatory elements on a CMS-1500 form must be completed for encounters, including box 10A, which identifies work-relatedness.

Encounter data helps us evaluate network and physician-specific utilization of ambulatory services and is an important aspect of our quality improvement program. All claims must be submitted within 180 days of the date of service.

Services Requiring Claims Submission

The following are examples of typical professional services that require claims submission:

- All office evaluation/management services, including new and established patient office visits, new and established patient preventive visits, and office consultations
- Surgical services
- Hospital visits and inpatient consultations
- Lab work, X-rays, and EKGs

Required Information
To ensure prompt payment, complete all mandatory fields on the claim form including, but not limited to:

- Personal information that identifies the member as a subscriber or dependent of a subscriber, and other pertinent data
- Coverage information, including the member's specific plan; coverage from other carriers; and any information that can help identify whether another party is financially liable for the charges
- Identifying rendering physician/provider information
- Identifying referral physician/provider information, if appropriate
- Charge of the service
- Patient treatment information, including diagnosis, CPT®, or HCPCS® code for the service and any applicable modifier(s), date services were rendered, and service site
- Tax identification number (TIN)

When the required information is not included, the claim will be denied. A new claim with correct and complete information must be submitted in order for a denied claim to be reconsidered. The Claims Adjustment Request Form, to be completed and submitted with a corrected claim, is available on the provider section of BCBSRI.com.

Procedures
1. Complete a CMS-1500 claim form.

2. Submit the form to BCBSRI.

To be considered for benefit payment, you must submit a clean claim (as defined above) within 180 days of the date of service or completion of an inpatient stay, or monthly in the case of an extended stay. Although not submitted for payment purposes, encounter claims must also be received within the same timeframe.

Claims submitted after the time limit will be denied. Please remember that in accordance with your participating physician/provider agreement, you may not "balance bill" patients for services that were denied because you did not meet timely filing requirements.

Allowable Fees

Participating physicians/providers are required to accept as payment in full the amount allowed by BCBSRI for covered services less any applicable copayment or coinsurance collected from the member at the time of service. Disputed payments will be reconsidered upon request.

Appeals of Payment Determinations

You are entitled to a review and reconsideration of any claims payment that you believe is inaccurate or does not reflect an appropriate allowance for the services rendered. Administrative appeals are handled by BCBSRI's Grievance and Appeals Unit (GAU). GAU will acknowledge receipt of your appeal either orally via telephone or in writing via an acknowledgement letter. Our staff will complete the review and send you a determination letter. The entire process will be completed within 60 calendar days of our receipt of your appeal.

To report errors or request review of a payment, denial, or adjustment, call the Physician and Provider Call Center, or submit your provider appeal request through one of the following channels:

- Submit the claim directly through our secure provider portal
- Submit via email to:
- Submit via fax to: 401- 459-5668 (Medicare Products)
  401- 459-5005 (all other lines of business)

COVERAGE
Not Applicable

CODING
Not Applicable

RELATED POLICIES
Ordering Provider NPI Number Requirement
Claims Timely Filing – Inpatient Level of Care Appeals and Observation

PUBLISHED
Provider Update, November 2025
Provider Update, September 2022
Provider Update, November 2019
Provider Update, March 2018
Provider Update, February 2017
Provider Update, April 2013
Provider Update, March 2011

This medical policy is made available to you for informational purpos CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS
judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.