SECTION [XIX]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents. This section is required.}

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this [Contract; Policy]. Either You or the Provider must file a claim form with Us. If the Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling [XXX; the number on Your ID card] [or visiting Our website [at XXX]]. Completed claim forms should be sent to the address [in the How Your Coverage Works section of this [Contract; Policy]] [or] [on Your ID card]. You may also submit a claim to Us electronically by [sending it to the e-mail address [in the How Your Coverage Works section of this [Contract; Policy]; on Your ID card]] [or] [visiting Our website [at XXX]].

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within [120 days; 180 days; 12 months; 18 months] after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the [120-day; 180-day; 12-month; 18-month] period, You must submit it as soon as reasonably possible. [In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.]
{Drafting Note: The time to file a claim must be a minimum of 120 days. Plans may insert a number greater than 120 days. Commercial insurers (insurers subject to Article 32 of the New York Insurance Law) may insert the last sentence for individual policies.}

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim

determination procedure applies to contractual benefit denials [and Referrals]. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this [Contract; Policy].
{Drafting Note: Plans may insert "Referrals" as applicable.}

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this [Contract; Policy].

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination [or Referral]), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.
{Drafting Note: Plans may insert "referral" as applicable.}

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.