

The Maryland Insurance Administration (MIA) is the state agency that regulates the business of insurance in the State of Maryland. If you have a question about insurance or experience a problem, please do not hesitate to contact the MIA at 800-492-6116 or visit our website at www.insurance.maryland.gov.

This consumer guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

This publication has been produced by the Maryland Insurance Administration (MIA) to provide consumers with general information about insurance-related issues and/or state programs and services. This publication may contain copyrighted material which was used with permission of the copyright owner. Publication herein does not authorize any use or appropriation of such copyrighted material without consent of the owner.

All publications issued by the MIA are available free of charge on the MIA's website or by request. The publication may be reproduced in its entirety without further permission of the MIA provided the text and format are not altered or amended in any way, and no fee is assessed for the publication or duplication thereof. The MIA's name and contact information must remain clearly visible, and no other name, including that of the company or agent reproducing the publication, may appear anywhere in the reproduction. Partial reproductions are not permitted without the prior written consent of the MIA.

Persons with disabilities may request this document in an alternative format. Requests should be submitted in writing to the Director of Communications at the address listed below.



200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000 • 800-492-6116
800-735-2258 TTY
www.insurance.maryland.gov

www.facebook.com/MdInsuranceAdmin
www.twitter.com/MD_Insurance
www.instagram.com/marylandinsuranceadmin

HEALTH CARE BILLS:

FILING HEALTH INSURANCE CLAIMS



When you receive medical care, you usually pay the provider (doctor, hospital, therapist, etc.) your share of the bill. You expect your health insurer to pay the rest of the bill. To get that payment, the provider files a claim with your insurer.

But sometimes you may have to file a claim with the insurer yourself. This could happen if you see an out-of-network provider or if the provider doesn't accept your insurance.

If you need to file your own health insurance claim, here's what you need to know:

How do I file a claim with my insurer?

You'll find a claim form on most health insurers' websites, along with information on how to submit the claim. Look at your health insurance card for your insurer's website or a phone number to call for information about filing a claim.

What will I need?

You will need the following to file a claim:

- ***An itemized bill from your health care provider.*** Ask the provider for this. The bill should include the date you received care and a list of services you received with the provider's charge and a description and/or billing code for each service.

- ***Your personal information,*** including your social security number, your health insurance ID number, and, if you received medical care due to an accident or illness at work, your employment status.
- ***Whether to send payment directly to the provider or to you.*** If the insurer sends the payment to you, you're responsible for paying the provider.

When do I file the claim?

File the claim as soon as possible after you receive the medical care. Many insurers have a deadline to file a claim, such as no more than 90 days after you receive care.

Where do I submit the claim?

Look for an address on the claim form. If it's not there, check the insurer's website and the back of your health insurance card or call your insurer.

What happens after I file the claim?

After you file the claim, the insurer has a limited time to tell you if it will pay the claim. If the denial was because the insurer says the care is not medically necessary, the insurer has 30 working days to make a decision if care has not been provided yet, and 45 working days to make a decision if the care has been provided. If the insurer denied the claim for other reasons, the insurer has 60 working days to issue a decision.