NEW TIMELY FILING GUIDELINES

Please note that one month equals 30 days on average, therefore 6 months equals 180 days.

- When Medicaid is the primary insurer providers have 6 months from the date of service to submit a claim
- When Medicare is the primary insurer providers have 6 months from Medicare's paid date to submit a claim or 6 months from Medicare's denied date to submit a claim
- When Other Insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim
- For an inpatient claim, providers have 6 months from the discharge date to submit a claim
- When a provider has been granted retro-enrollment they have up to 12 months from the date of service, or an additional 45 days from the date of notice of enrollment, whichever is later, to submit a claim
- When a recipient has been granted retro-eligibility providers have 12 months from the date of service to submit a claim
- Providers must request an adjustment to a PAID claim within 12 months from the original paid date when the adjustment would **result in a positive financial outcome for the provider**
- Providers may request an adjustment to a PAID claim within 3 years from the original date of service when the adjustment would **result in a negative financial outcome for the provider**
- Providers have 6 months from the initial Medicaid denial to submit a corrected claim
- Providers have 3 months from the initial Medicaid timely filing denial to submit a timely filing reconsideration request