

**Required Data Fields for Prompt Payment Reporting
Ohio Department of Insurance**

Reporting Period: January 1 through March 31, Due May 1, 2009.

Reporting Period: July 1 through September 30, Due November 1, 2009.

Item	Description
1	Third-Party Payer Name
2	Third-Party Payer NAIC Number
3	Federal Identification Number
4	Mailing Street Address
5	City
6	State
7	Zip Code(s)
8	Contact Name (name of individual ODI may contact w/ potential questions)
9	Company Contact Title (title of contact person)
10	Company Contact Phone Number
11	Company Contact E-mail Address
12	Company Website Address, if any
13	Number of Total Claims Paid (> Zero dollar payment) During Reporting Period*
14	Number of Total Claims Denied (Zero dollar payment) During Reporting Period*
15	Number of Claims Denied as Duplicative (<i>These are also included in "Denied" count above.</i>)
16	Number of Claims Paid w/in 30 Days of Receipt Date
17	Number of Claims Denied w/in 30 Days of Receipt Date
18	Number of Claims Paid More Than 30 Days After Receipt but within the 45 Day Statutory Processing Time
19	Number of Claims Denied More Than 30 Days After Receipt but within the 45 Day Statutory Processing Time
20	Number of Claims Paid After the 30-Day Statutory Processing Time for Which No Additional Information Was Requested
21	Number of Claims Denied After the 30-Day Statutory Processing Time for Which No Additional Information Was Requested
22	Number of Claims Paid Beyond 45 Days of Statutory Processing Time
23	Number of Claims Denied Beyond 45 Days of Statutory Processing Time
24	Number of Claims Which Included Interest Paid

** The sum of these fields should be the Total Claims Processed/Adjudicated During the Reporting Period.*

|| Check here if you report claims data based upon line item(s) rather than individual claim form.

(See reverse for term definitions)

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Definitions:

1. Claim – Any request submitted to a third-party payer for benefits of proceeds under a benefit plan or contract on a standardized health claim form. Self-funded claims submitted under ERISA plans and capitated claims should be excluded.
2. Claims Paid – Claims closed with an amount paid **or any amount applied to deductible of greater than zero dollars**. This term includes partially paid claims and/or claims with any number of line items paid.
3. Claims Denied – Claims closed with no payment (zero amount paid). **Do not include claims that were applied to the deductible**, as these should be reported as Claims Paid.
4. Statutory Processing Time – The actual claims **processing** time in calendar days calculated in accordance with Sections 3901.381 (B)(2)(a) and (b) of the Ohio Revised Code, which provide in pertinent part:

The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a claim.

* * *

(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party's compliance with the time period of not more than forty-five days.