HOUSE BILL No. 5273

October 17, 1991, Introduced by Reps. Stallworth, Wallace, DeMars, Dobronski, Joe Young, Jr., Baade, Kilpatrick, Gire, Olshove, Kosteva, Gubow, Willis Bullard, London, Hoffman, Dolan, Middleton, Dalman, Brackenridge, Profit and Barns and referred to the Committee on Public Health.

A bill to amend section 405 of Act No. 350 of the Public Acts of 1980, entitled as amended

"The nonprofit health care corporation reform act,"

being section 550.1405 of the Michigan Compiled Laws.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 405 of Act No. 350 of the Public Acts of 1980, being section 550.1405 of the Michigan Compiled Laws, is amended to read as follows:

Sec. 405. (1) ~~A~~ SUBJECT TO SUBSECTION (2), A health care corporation, in consultation with the department of social services, shall develop a single billing form to be used for the billing of each of the following: hospital services, physician services, and pharmaceutical services. If such forms are subsequently developed by the federal government, they may be

HOUSE BILL No. 5273

used in the place of forms developed pursuant to this subsection.

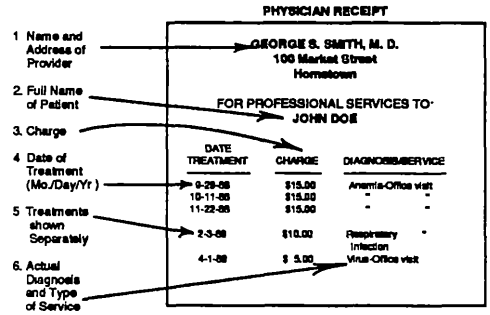
(2) BEGINNING OCTOBER 1, 1992 AND CONTINUING UNTIL RULES ARE PROMULGATED UNDER SECTION 2240 OF THE INSURANCE CODE OF 1956, ACT NO. 218 OF THE PUBLIC ACTS OF 1956, BEING SECTION 500.2240 OF THE MICHIGAN COMPILED LAWS, A HEALTH CARE CORPORATION SHALL REQUIRE ONLY THE FOLLOWING STANDARD MEDICAL CLAIM FORM BE USED BEFORE A CLAIM IS PAID:

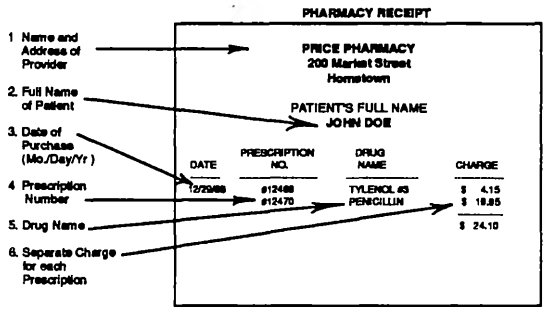
MEDICAL CLAIM FORM

INSTRUCTIONS FOR FILING A CLAIM (PLEASE TYPE OR PRINT)

- FOR EACH ELIGIBLE FAMILY MEMBER, DEPENDENT OR SPOUSE SEPARATE ALL ITEMIZED BILL(S), RECEIPT(S), COPIES OF EXPLANATION OF BENEFITS FORMS OR CHECK VOUCHERS.
- COMPLETE A SEPARATE CLAIM FORM FOR EACH ELIGIBLE MEMBER.
- ATTACH EACH MEMBER'S ITEMIZED BILL(S) OR RECEIPT(S) TO HIS/HER COMPLETED CLAIM FORM(S). ALL COMPUTERIZED RECEIPTS SUBMITTED MUST INCLUDE THE PROVIDER SIGNATURE AND PROVIDER CODE.
- IF APPLICABLE, ATTACH COPIES OF YOUR EXPLANATION OF MEDICARE BENEFITS FORM OR MEDICARE VOUCHER.
- SAVE COPIES OF ALL ITEMS SUBMITTED.
- CLAIM FORM SHOULD BE SIGNED BY THE (INSERT INSURED OR SUBSCRIBER).

EXAMPLES OF PROPERLY ITEMIZED RECEIPTS





CASH REGISTER RECEIPTS, CANCELLED CHECKS, MONEY ORDER RECEIPTS, UN-SIGNED COMPUTERIZED RECEIPTS OR STATEMENTS AND PERSONAL ITEMIZATIONS **ARE NOT** ACCEPTABLE AND IF SUBMITTED BECOME THE PROPERTY OF (INSERT COMPANY NAME).

NOTE:

FOR BEST SERVICE, PLEASE SUBMIT YOUR MEDICAL CLAIMS TO US AS SERVICES OCCUR.

(INSERT INSURED OR SUBSCRIBER) LAST NAME	FIRST NAME	
STREET ADDRESS	CITY	
STATE / ZIP CODE	(INSERT INSURED'S OR SUBSCRIBER'S) CONTRACT NUMBER ▶	GROUP NO. ▶
PATIENT LAST NAME	FIRST NAME	PATIENT'S DATE OF BIRTH ▶ MO. DAY YR.
PATIENT'S RELATIONSHIP TO (INSERT INSURED OR SUBSCRIBER) ☐ SELF ☐ SPOUSE ☐ DEPENDENT	PATIENT SEX ☐ M ☐ F	WORKER'S COMP. ☐ YES ☐ NO
WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO	ACCIDENT ☐ YES ☐ NO	IF YES, GIVE DATE OF ACCIDENT ▶ MO. DAY YR.
SPOUSE'S SOCIAL SECURITY NUMBER ▶	SPOUSE'S DATE OF BIRTH ▶ MO. DAY YR.	(INSERT INSURED'S OR SUBSCRIBER'S) DATE OF BIRTH ▶ MO. DAY YR.
OTHER MEDICAL COVERAGE ☐ YES ☐ NO	NAME OF OTHER COMPANY	FOR COMPANY USE ONLY
STREET ADDRESS AND CITY OF OTHER COMPANY	STATE	ZIP CODE

CERTIFICATION STATEMENT

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THE ATTACHED MATERIAL IS CORRECT AND UNALTERED AND THAT THE EXPENSES WERE INCURRED BY THE ABOVE NAMED PATIENT. I UNDERSTAND ALL MATERIAL SUBMITTED BECOMES THE PROPERTY OF (INSERT COMPANY NAME) AND MAY NOT BE RETURNED. I REALIZE FALSE RECEIPTS OR FRAUDULENT ALTERATIONS OF THESE MATERIALS WILL RESULT IN CIVIL OR CRIMINAL PROSECUTION. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS OR REVIEW THIS CLAIM.

SIGNATURE	
DATE	TELEPHONE NO. ( )
CLAIM NUMBER (FOR COMPANY USE ONLY)	

YOUR RIGHT TO CONFIDENTIALITY

WE WILL NOT RELEASE ANY INFORMATION ABOUT YOU EXCEPT: 1) WHEN YOU ASK US IN WRITING, OR 2) WHEN RELEASE (TO ANOTHER INSURANCE COMPANY FOR EXAMPLE) IS NECESSARY TO PROCESS OR REVIEW A CLAIM. WE WILL TELL YOU WHICH INFORMATION WE RELEASED TO WHOM, IF YOU REQUEST IT.

MAIL TO: (INSERT COMPANY'S NAME AND ADDRESS OF COMPANY OR REGIONAL CLAIMS CENTER.)

04284'91

(3) ~~(2)~~ A health care corporation shall provide each member with a detailed and accurate explanation of his or her total bill for services rendered by a health care provider and provided under a certificate with a health care corporation, including charges for specific types of services rendered, the date of services rendered, the amounts reimbursed by the corporation, and the reasons for denial of any payments for expenses incurred.