

Filing Limit Provider Appeals

- Filing limit appeals must be received within 45 days of the original EOP date.
- Any claim with a date of service more than 95 days old will not be considered for filing limit appeal.
- Any appeal received after the applicable appeal filing limit will not be considered and cannot be appealed.
- Members cannot be held liable for claims denied for exceeding the appeal filing limit.

Appeal Requirements

All filing limit appeals must be submitted with:

- A completed Scott & White Health Plan [Provider Appeal Request Form](#) (claims submitted without this form will be treated as a first submission, which may result in a denial).
- CMS-1500/UB claim form.
- Supporting documentation (see “Supporting Documentation” below).

The following information is required on backup documentation to validate and cross-reference the information on the claim being appealed:

- Patient name.
- Date(s) of service.
- Charges being appealed.
- Date the first claim was submitted to Scott & White Health Plan.
- If the date of service is over the initial filing limit, resending an appeal will result in a filing limit denial. [See Claims Submission Process.](#)

Supporting Documentation

EDI Claims Supporting Documentation

When appealing an EDI claim that was rejected for exceeding the filing limit, only the following documentation will be accepted:

- A copy of an EDI vendor report indicating that the claim was accepted for processing by Scott & White Health Plan within the filing limit period, Scott & White Health Plan Response Report, or information from your 277 Acknowledgement (277 ACK). Providers who submit claims through intermediaries are responsible for obtaining these payor rejection reports.

*A copy of the Patient Account Ledger is **not** acceptable documentation for EDI claims.*

Paper Claims Supporting Documentation

When appealing a paper claim that was rejected for exceeding the filing limit please submit proof that your claim was filed timely.

Coordination of Benefits (COB) – Related Supporting Documentation

All COB-filing limit appeals must be submitted on paper with a completed Scott & White Health Plan Provider Appeal Request Form and a copy of the Explanation of Benefits from the other insurer attached, showing timely submission to Scott & White Health Plan within 95 days from the date the other insurer adjudicated the claim.

- If the denial is *upheld*, a provider appeal letter will be sent.
- If the denial is *reversed*, the adjusted claim will appear on a future EOP.

Re-Appeal

- Providers may submit additional supporting documentation for any filing limit appeal denied for insufficient documentation as long as it is received within 45 days from the original denial date.
- When a denial is upheld on reappeal, Scott & White Health Plan will not consider any further.

Claims Appeals Address

Mail all provider claim appeals to:

Scott & White Health Plan
MS-A4-126 Claim Appeals
1206 West Campus Drive
Temple, TX 76502