DENIED CLAIMS REPORT

What is captured in this report?

The Denied Claims Report presents claims that have been denied for various reasons, including duplicate submission, individual benefit maximum met, lack of response from member, patient not eligible at time of service, etc. It also presents claims that were denied upon adjustment. The report displays patient names and their relationship to the employee. It also details the claim number, charged amount, and provider information.

Why run this report?

This report is designed to assist the user in understanding the claims being denied on behalf of the plan. Users may find this report useful when presented with questions from employees about specific claim denials.

What are the required data parameters?

Users are required to enter a range of paid dates and the desired product. The product refers to applicable medical, dental, vision or other coverage.

What time periods are available?

The data is refreshed nightly and is available as far back as 36 months from the current month. Users typically create this report at month end, although any date range within the available time periods may be selected.

Glossary of Terms

For a complete glossary of terms, please see the Getting Started Guide.