TCC Benefits Administrator℠
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What are the top reasons why your medical claims could be denied?

1. **Accident information is needed** – Was this claim related to an accident? If your claims were related to an accident your plan works with lawyers to recoup the payments if a third-party was at fault for the accident. This assists in minimizing premium cost increases.

2. **Full-time student status** – Is the claimant a full time student? Information, such as a letter from the registrar or a copy of the class schedule is needed at least twice a year to verify your dependent is still a full-time student. Proof of full-time student status is required once they exceed the age of a covered dependent, located in your summary plan description.

3. **Letter of creditable coverage** not on file – Did you have creditable coverage from another carrier that would decrease or eliminate pre-existing? If you haven't worked for your organization for at least a year we need clarification if you had previous coverage. All members are reviewed for pre-existing medical conditions that may be denied in accordance with the rules noted in your summary plan description. This is done so the plan doesn't accept an unreasonable amount of liability and assists in minimizing future premium increases.

4. **Coordination of Benefits** (COB) information is needed – Does the claimant have alternate insurance coverage? If you have alternate insurance coverage you are required to make us aware of this so we may coordinate with this other carrier and pay as required up to your liability amount. Failure to make your employer aware of this may be cause for disciplinary actions as this helps the plan minimize future premium increases.

5. The claims are related to **Subrogation** – a third party could be liable for all or a portion of the claim. As noted in #1 above, further denials are caused because we have identified a third-party was involved and additional claims have been submitted for payment.

6. **Pre-existing condition** – Is the claim related to a pre-existing condition? If it appears that a claim is a pre-existing condition prior to coming on the current group health plan the claim may be denied. This assists in decreasing the plan from an unreasonable amount of liability.

7. **Office notes** from the physician are needed. There are times when claims are submitted that the charges or services performed need further clarification prior to payment being made. This assists the administrator in ensuring the correct level of benefits is paid in an accurate and timely manner.

8. **Itemized bills** are needed from the provider. In the majority of cases this is caused by hospital bills being submitted without the appropriate documentation. This documentation assists the administrator in ensuring the correct level of benefits is paid in an accurate and timely manner.

9. **Current year claim form** – This is used to update your demographic, other insurance, or student status information. This usually takes place once a year, but sometimes it depends on what your summary plan description states. The administrator may ask for your address, dependent information, alternate insurance information or other information needed to ensure we are processing your group's health plans in accordance with your group health plans schedule of benefits.

The intent of this document is to make you aware of the common reasons for claim denial and comments made on your Explanation of Benefits form that TCC Benefits Administrator provides. If your claim is denied and you provide the requested data within the allowable time limits, your claim will then be reconsidered as quickly as possible.

Reminder: Information must be received within 12 months from the incurred date of service to be considered for payment.

If you would like further information about your specific plan of benefits please refer to your summary plan description.

For questions or further information, please contact our customer service representatives by calling 843-722-2115.