HOUSE BILL No. 5274

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 Act No. 218 of the Public Acts of 1956, entitled as amended

"The insurance code of 1956,"

as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, by adding sections 2240 and 2241.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, is amended by adding sections 2240 and 2241 to read as follows:

SEC. 2240. (1) BEGINNING OCTOBER 1, 1992 AND CONTINUING UNTIL RULES ARE PROMULGATED UNDER SUBSECTION (2), EACH DISABILITY INSURER SHALL REQUIRE ONLY THE FOLLOWING STANDARD MEDICAL CLAIM FORM BE USED BEFORE A CLAIM IS PAID:

HOUSE BILL No. 5274

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

PHYSICIAN RECEIPT

1 Name and Address of Provider → GEORGE S. SMITH, M. D.
100 Market Street
Hometown

2. Full Name of Patient → FOR PROFESSIONAL SERVICES TO JOHN DOE

3. Charge

4 Date of Treatment (Mo./Day/Yr.) → 5 Treatments shown Separately → 6 Actual Diagnosis and Type of Service

DATE TREATMENT	CHARGE	DIAGNOSIS/SERVICE
9-29-88	$15.00	Anemia-Office visit
10-11-88	$15.00	" "
11-22-88	$15.00	" "
2-3-89	$10.00	Respiratory Infection
4-1-89	$ 5.00	Virus-Office visit

PHARMACY RECEIPT

1 Name and Address of Provider → PRICE PHARMACY
200 Market Street
Hometown

2. Full Name of Patient → PATIENT'S FULL NAME JOHN DOE

3. Date of Purchase (Mo./Day/Yr.) → 4 Prescription Number → 5 Drug Name → 6 Separate Charge for each Prescription

DATE	PRESCRIPTION NO.	DRUG NAME	CHARGE
12/28/88	#12468	TYLENOL #3	$ 4.15
	#12470	PENICILLIN	$ 10.85
			$ 24.10

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.)

(2) THE COMMISSIONER SHALL PROMULGATE RULES PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT OF 1969, ACT NO. 306 OF THE PUBLIC ACTS OF 1969, BEING SECTIONS 24.201 TO 24.328 OF THE MICHIGAN COMPILED LAWS, ESTABLISHING, IN PLAIN ENGLISH, A STANDARD MEDICAL CLAIM FORM TO BE USED BY EACH DISABILITY INSURER, EACH HEALTH CARE CORPORATION, AND EACH HEALTH CARE MAINTENANCE ORGANIZATION. THE STANDARD MEDICAL CLAIM FORM SHALL REQUIRE PROVIDERS TO LIST EACH PROCEDURE AND SERVICE PERFORMED PURSUANT TO THE CODE IDENTIFIED FOR THAT PROCEDURE OR SERVICE IN THE PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY. THE COMMISSIONER SHALL SUBMIT THE PROPOSED RULES FOR PUBLIC HEARING PURSUANT TO ACT NO. 306 OF THE PUBLIC ACTS OF 1969 BY OCTOBER 1, 1994.

(3) UPON AN INSURED'S REQUEST, A DISABILITY INSURER SHALL RELEASE TO THE INSURED A COPY OF THE INSURED'S STANDARD MEDICAL CLAIM FORM WITH INFORMATION EXPLAINING THE CODING FOR THE PROCEDURE OR SERVICE PERFORMED.

SEC. 2241. THE COMMISSIONER SHALL ENCOURAGE AND PROMOTE THE ESTABLISHMENT AND USE OF REGIONAL CLAIMS CENTERS AND OTHER MEANS TO REDUCE THE ADMINISTRATIVE EXPENSES OF DISABILITY INSURERS.