Print Form

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TIMELY CLAIM FILING WAIVER FORM FOR PROVIDERS

Please Complete this Form to Request a Waiver for Timely Claim Filing

Rendering Provider Name: _____

Patient's Name: _____ **Patient's ID #:** _____

Date of Service: _____ **Claim #:** _____

Contact Name: _____ **Contact Ph #:** (_____) _____

Reason for requesting a timely filing waiver: ***(Required)***

_____

_____

_____

_____

_____

Please submit any of the following documents listed below to support your request:

- Copy of Primary Carrier's EOB
- Copy of denial or exhaust letter from Third Party Liability (TPL)
- Copy of original claim showing date stamp (if paper claim was submitted)
- Additional documentation that provides proof of timely filing attempts such as: certified mail receipt, documented timeline of follow-up with payer or proof of electronic claim submission.

Please mail or fax this completed form and all required documents to:

UHA-Contracting Services
700 Bishop Street, Ste. 300
Honolulu, HI 96813
Fax: 866-572-4383

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FOR UHA USE ONLY: **Denial Reasons:**

Date Reviewed:	_____	1 – Lack of Information	2 – Documentation does not support waiver
		3 – Exceeds COB primary exception (Six months filing from date of primary payment; one year for Medicare primary payment)	4 – Other (see Comments)
Comments:			