1.12 Timely Filing

Claims for covered services must be filed within 12 months from the through/ ending date of service. Providers are encouraged to submit their claims as soon as possible after the dates of service.

The following are reasons allowing consideration for overriding the timely filing edit:

- Claims filed within 12 months from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim. The original TCN must be placed in the appropriate field on the resubmitted claim. Corrected claims must be submitted no later than two years from the initial date of service. The appropriate field for each corresponding claim form is shown in the table below.

FORM	FIELD
CMS-1500	Field 22
UB-04	Field 64
ADA DENTAL	Field 35
CROSSOVER A	None
CROSSOVER B	None

- Claims over 12 months old can be processed if the beneficiary's Medicaid eligibility has been approved retroactively by the Division of Medicaid or the Social Security Administration through their application processes. When Medicaid is the primary coverage, claims can be filed as a hardcopy or electronically since proof of retroactive determination is no longer required.

- The 12-month filing limitation for newly enrolled providers begins with the date of issuance of the provider eligibility letter.

- Medicare crossover claims for coinsurance and/ or deductible must be filed with the Division of Medicaid within 180 days of the date of service.

- The 180-day filing limitation for Medicare/ Medicaid crossover claims will be determined using the Medicare payment register date as the date of receipt by Medicaid. Claims filed after the 180-day timely filing limitation will be denied. Claims over 180 days old can be processed if the beneficiary's Medicaid eligibility is retroactive. Paper crossover claims must be filed and processed within 180 days of the Medicaid retroactive eligibility determination date.