Texas Department of Insurance Prompt Pay Reporting Information

The Claims Data Reporting database has been changed to a new software application for data reporting.

Significant changes with the new database

1.) Setting up user accounts and passwords will now be done electronically. If you have forgotten your password, login to the Department's public authentication program and request a temporary password. One will be emailed to you within a few minutes. You will no longer have to email or call the Department to request a password reset.

2.) All quarterly reports due in a particular quarter will no longer be locked down after submission. They will remain open until the end of the reporting period. Rather than requesting a submitted report be invalidated or asking the Department to edit your report, you will be able to make any necessary changes through the last day of the reporting period.

3.) The new database application has been programmed to lock down at 11:59 p.m., CST, on the statutory reporting deadline date. This means that carriers who fail to enter their data on or before the reporting deadline will not be able file their reports without requesting the report be unlocked for a late submission. If you know in advance that you will not be able to submit your data by the reporting deadline, you may submit an email requesting an extension. The extension request must be received and the extension granted prior to the reporting deadline.

4.) The Department will now be able to unlock reports from prior quarters that need to be amended or are being reported late. To request a report be unlocked, send an email to promptpay@tdi.texas.gov requesting the report be unlocked for revision. You must identify your company's name, its TDI or NAIC ID#, the type of report, the year, and the quarter and provide a brief explanation why the report needs to be unlocked.

5.) All authorized reporters for a company/HMO, including any authorized delegated entitles, will be able to **view all reports** submitted for the company/HMO during the reporting period or unlocked period, regardless of who submitted the reports.

6.) The Department will no longer be emailing copies of the quarterly or annual reports to the company/HMO on request. You will be prompted to verify your information and print a copy of your report when you click on the submit button. If you forget to print a copy, you are able to re-open the report and print it.

7.) The comment fields on the reporting forms have been modified to accept up to 4000 characters. Previously, carriers often provided explanatory letters or memos outside the database because the 500-character limit did not allow sufficient space to adequately provide explanatory comments. Increasing the comment field to 4000 character should remove the necessity for carriers to submit separate explanatory letters or memos. The Department encourages carriers to keep their explanatory comments brief.

Texas Department of Insurance Provider Claims Data Call

Accessing the new claims data reporting system

- To login to the new Claims Data Reporting application, carriers must have first provided TDI with a listing of authorized reporters, their email addresses, and the carriers' NAIC numbers. The authorized reporters must have set up a user's account in the TDI Public Account Management Site at https://appscenter.tdi.texas.gov/cleanclaims/p/home and select a "role" to the Claims Data Reporting database.
- Please send an email to PromptPay@tdi.texas.gov, when these steps have been completed. TDI must grant access to the database application before you are able to access it. The granting of access rights to the database may take a few working days to complete.

Login instructions

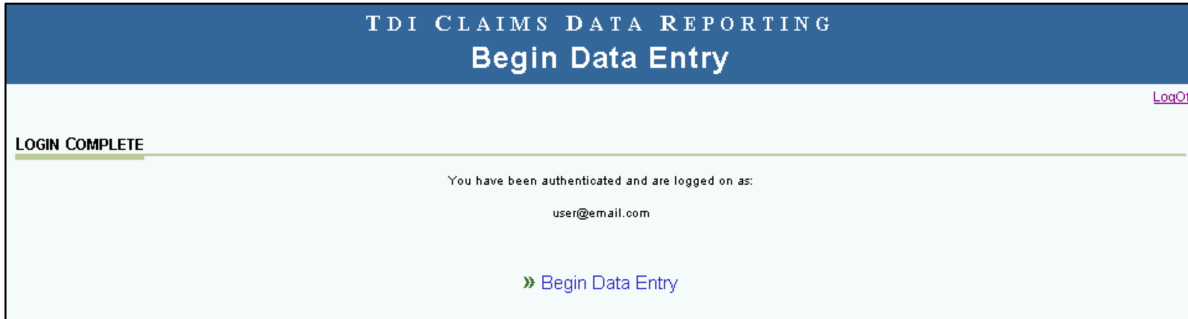
1. Once you have set up your user account, click on the link to the database (https://appscenter.tdi.texas.gov/cleanclaims/p/home) to open the Company Login page:

TDI CLAIMS DATA REPORTING
Company Login
LogOff
LOGIN
Welcome to the new TDI Claims Data Reporting Application, which has been activated as of October 2009. Prior to using this new application for the first time, you must create a new login account. To create your new login account, please proceed to the "First-Time User" section.
If you are a returning user, please log in:
Email Address (case-sensitive)
Password
Login Reset
Lost your password ? Go to the TDI Public Account Management application.
FIRST-TIME USER ?
Prior to using this application for the *first time*, you must:
1. Create a new account using the TDI Public Account Management application.
2. Request the *Claims Data Reporting* role for this application,using the TDI Public Account Management application.
» go to TDI Public Account Management

Field name	Tip
Email address	You must enter your email address exactly as you entered it when registering your user account. Please remember that this field is case sensitive.
Password	You must enter your new password, which you established when registering your user account information.
Login	Click this button to gain access to the database application when you have entered your email address and password.
Forgot your password?	If you are unable to remember your password, you will need to access the TDI Public Account Management application to secure a new password. A link to the application is provided on the company login page.

Field name	Tip
First time user?	You only need to set up a user account one time. If you report data for multiple carriers, the carriers will need to send an email to the PromptPay@tdi.texas.gov mailbox listing your email address as an authorized reporter and including the carrier's identification number. This is needed for each of the carriers so that TDI may associate your user account with the company reports. When you have set up a user account, TDI must grant access to the database application before you are able to access it. The granting of access rights to the database may take a few working days to complete.

2. From the login screen you will be taken to the Begin Data Entry screen:



Field name	Tip
Begin data entry	If you've correctly entered your email address and password, clicking on the "Login" button will open a screen confirming that you are logged into the database application. You will need to click on "Begin Data Entry."

Data entry instructions

1. After clicking on "Begin Data Entry," you will be directed to a page that lists all of the carriers that you have been authorized to report data for. If there are carriers listed for which you are not an authorized reporter, please notify the Department immediately and **do not open those reports**. You may notify the Department by contacting Nikki Kline at 512-463-6106 or by email at PromptPay@tdi.texas.gov If the list of carriers is not complete, you will need verify that the carrier sent an email to PromptPay@tdi.texas.gov listing your email address as an authorized reporter for their company/HMO and providing the carrier's identification number. You may verify this by contacting TDI at PromptPay@tdi.texas.gov.

Company Eid	NAIC Id	Company Name	Category Code	System Type Code
00000	11111	COMPANY1	LI	CL
0001	02468	COMPANY2	LI	CL
00002	98765	COMPANY3	HMO	CL

Field name	Tip
Select company	If you've correctly entered your email address and password, clicking on the "Login" button will open a screen confirming that you are logged into the database application. You will need to click on "Begin Data Entry."

2. Once you have selected the carrier that you will be reporting data for, you will be directed to a select report or exemption screen:

TDI CLAIMS DATA REPORTING
Select Report or Exemption Type

LogOff

Today is 07/01/2009

ACCEPTING DATA FOR

Reporting Year: 2009
Reporting Period: Quarter 2

reports / exemptions accepted 07/01 to 08/15 (inclusive)

Have you been authorized to make a Late or Amended Entry?

» Do Late or Amended Entries

HB610 QUARTERLY REPORT

» Enter Data for Quarterly HB610 Report
» Enter Exemption for Quarterly HB610 Report

SB418 QUARTERLY REPORT

» Enter Data for Quarterly SB418 Report
» Enter Exemption for Quarterly SB418 Report
(also serves as SB418 annual exemption)

SB418 ANNUAL REPORT

» Enter Data for Annual SB418 Report

Field name	Tip
Accepting data for	Verify that the year and reporting period reflect the the year and quarter that you are submitting data for. If the information is different, you should contact the Department at PromptPay@tdi.texas.gov.
Enter Data for Quarterly HB610 Report	Use this form to report provider claims paid under contracts that were last issued or renewed before August 16, 2003. TDI understands that many carriers may no longer have claims that fall into this category so those carriers will not use this form.
Enter Exemption for Quarterly HB610 Report	If the carrier has no provider contracts that were last issued or renewed prior to August 16, 2003 or if the carrier qualifies for an exemption to the HB610 reporting requirements, click on this link to enter a one-time exemption. The exemption will remain in the database for all future HB610 reports until the carrier requests the Department remove the exemption or until the Department notifies the carrier that the exemption request is invalid.
Enter Data for Quarterly SB418 Report	If the carrier has claims data for providers whose contracts were last issued or renewed on or after August 16, 2003, click on this link.
Enter Exemption for Quarterly SB418 Report	If the carrier believes it is exempt from reporting data as required under TIC Chapters 843 and 1301, click on this link to enter a one- time exemption. The exemption will remain in the database for all future SB418 reports until the carrier requests the Department remove the exemption or until the Department notifies the carrier that the exemption request is invalid.
Enter Data for Annual SB418 Report	The annual declinations data may only be entered during the second quarter reporting period, which ends on August 15. Click on this link to open the reporting form for the annual declinations report. If you click on this link during any reporting period other than the second quarter, you will receive a message stating that the SB418 Annual Report is not being accepted at this time.

3. If you click on a link to open the data report, a Select Delegated Entity screen will open.

TDI CLAIMS DATA REPORTING

Select Delegated Entity

LogOff

SELECT DE

No Delegated Entity used for this report

Select a Delegated Entity for this report

Previously used DE names for this company & report type:

DE1

Enter a New Delegated Entity name for this report

Submit

Field name	Tip
No Delegated Entity for this report	Check this field if the carrier is entering its own data and does not have claims data that was provided by a delegated entity. Each carrier that uses delegated entities to pay claims **must submit a quarterly on-line data report for each of the delegated entities separately**. If a carrier pays claims in addition to those handled by its delegated entity, then select this option for the report containing only the data for the claims handled by your company.
Select a Delegated Entity for this report	Check this field and select the delegated entity's name if you are a carrier entering data submitted to you by a delegated entity or if you are a delegated entity entering the data on behalf of a carrier, then continue to the next field. The drop-down menu will be automatically populated with delegated entity names that have been used in prior reports for the carrier.
Enter a New Delegated entity name for this report	Check this field if you are a carrier entering data submitted to you by a delegated entity or if you are a delegated entity entering the data on behalf of a carrier and the drop-down menu in the prior field is not populated with the delegated entity's name. You will need to enter the delegated entity's **legal name** (as licensed by the Department) in the field next to the third radial button. The Delegated Entity, if paying claims, must be licensed by the Department as a third-party administrator.
Submit	Click submit to continue to the next screen. **Note:** The screen will not advance unless one of the three fields is completed.

Exemption instructions

1. If you believe your company/HMO is exempt from reporting data under TIC Chapters 843 and 1301, you will need to select the "Enter an exemption" for HB610 and/or SB418, as applicable, from the select report or exemption screen. If you believe you are exempt from both reports, you will need to enter an exemption request for each report. If you are only exempt from entering HB610 data, you may select only that exemption and still enter data under the SB418 report.

Enter Exemption For HB610 Quarterly Report

LogOff

PLEASE NOTE

- If you do not represent the following company, please log out of this application, and immediately contact the Texas Department of Insurance.
- This is a long-term exemption. It does not need to be requested each quarter, or each year.
- Please do not use the *Back* button in your browser, or you may lose data that you have entered.

Company Legal Name:	COMPANY1
TDI Company Number:	00000
NAIC Company Number:	11111

CONFIDENTIALITY

* **Company asserts that its responses hereto are proprietary and/or confidential.**

Please note that your response to this question will affect how TDI would respond in the event it receives a request for this information pursuant to the Public Information Act, Texas Government Code, Chapter 552.

Yes

No

ENTER EXEMPTION DATA

Exemption Reason: (see detail below)	Church
Additional Explanation for Exemption (if "Other" selected)	

Save Exemption

Reason	Description
Church	All of your PPO or HMO business written in Texas is under self-funded church employee plans
Government plans	All of your PPO or HMO business written in Texas is funded through federal plans such as Medicare, Medicare Supplement, Medicaid, or CHIP plans
No HB610 Contracts	You have no active plans/policies in Texas that fall within the requirements of TIC Chapters 843 and 1301 with provider contracts issued or renewed prior to August 16, 2003
Not in Texas	No individual or group PPO or HMO plans in force in Texas
Other	Other means none of the above or a combination of several of the above. If you select other, you must provide an explanation / description of why your company / HMO is exempt from this data call.
Other Carrier	Single service carrier whose data is reported through another carrier
Run off	You are no longer issuing new plans or renewing existing plans, and you have less than 100 lives insured in Texas and less than 100 claims still active
Self-funded	All of your PPO or HMO business written in Texas is under self funded ERISA, federal, state, or local government employee plans
Worker Comp	All claims were paid pursuant to a worker's compensation insurance policy

Field name	Tip
Please Note	Before entering an exemption request, make sure that the carrier's legal name and TDI & NAIC company numbers reflect that of the carrier you are entering an exemption for. If it does, then continue to the confidentiality field.
Confidentiality	You must check either yes or no before the exemption will be accepted.
Enter Exemption Data	Click on the arrow button next to the exemption reason and select one of the reasons for exemption listed in the drop-down list. If none of them are appropriate or if more than one is appropriate, select "Other." **Note:** The reason "No HB 610 Contracts" is only applicable to the HB610 exemption. Do not use it for the SB 418 exemption requests.
Additional Explanation for Exemption	If "other" has been selected from the exemption drop-down list, please provide an explanation of the carrier's reason for exemption.

Pharmacy claims reporting instructions

Pursuant to the requirements of 28 Texas Administrative Code Sections 21.2821(d)(19)-(23), carriers should report data for all electronically submitted, affirmatively adjudicated pharmacy claims subject to prompt pay requirements by Texas Insurance Code Sections 1301.104 and 843.339.

Carriers have previously reported that prescription drugs dispensed by an institutional provider are a component of the institutional claims and are not the electronically submitted and affirmatively adjudicated claims that are the subject of the 18-day statutory claims payment period. Section 21.2821 recognizes this and does not split the reporting requirements into institutional and non-institutional categories. Therefore, carriers should report all electronically submitted, affirmatively adjudicated pharmacy claims in the "Non- institutional" field.

Example for SB 418 quarterly data entry screen

Reporting Year	2009
Reporting Period	Third Quarter
Non-Institutional Provider Data	
Number of Claims Received:	200,000
Number of Clean Claims Received:	200,000
Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	
Pharmacy:	50,000
Electronic:	150,000
Non-Electronic:	0

Note: Enter pharmacy claims data in the Non-Institutional section of the data entry screen, as shown below.

Tips to assure accurate data reporting

Company contact information

Field name	Tip
Contact name	Use this field to enter the name of the person that TDI may contact if there are questions regarding the data reported.
Title	Please enter the title of the contact person.
Direct telephone number	Please enter the direct telephone number of the contact person.
Mailing address	Please enter the mailing address of the contact person.
Email address	Please enter an email address for the contact person; don't enter a street address. If TDI staff members have questions about the data, they will contact this person.
TDI may release this email address in response to a public information request	This field requires you to provide an agree or do not agree response. Please indicate whether TDI may release the contact person's email address in response to a public information request.

HB 610 quarterly data collection form

Field name	Tip
Number of clean claims paid	Verify that the figure reported for number of clean claims paid is the sum of the figures reported in these categories: • Number of clean claims **paid on or before the 45th day** following receipt of claim (the clean claims that were paid timely). • Number of clean claims **paid after the 45th day** following receipt of claim.
Number of clean claims paid After the 45th day following receipt of claim	Verify that the figure entered is the sum of the figures reported in these categories: • Number of clean claims **paid on day 46-59** following receipt of claim. • Number of clean claims **paid on day 60-89** following receipt of claim. • Number of clean claims **paid on day 90 or later** following receipt of claim.

SB 418 quarterly data collection form

Field name	Tip
Number of clean claims paid within the applicable statutory claims payment period	Verify that the figure reported is the **number of clean claims paid timely**, which is, paid within 18 days for electronically submitted pharmacy claims, 21 days for non-electronic pharmacy claims, 30 days for electronic claims, and 45 days for non-electronic claims. Do not include the number of claims paid late.
Number of clean claims paid between 1 and 45 days after the end of the applicable statutory claims payment period	This field is for clean claims that are paid **late**. Verify that the figure reported is the number of clean claims that **were paid 1 to 45 days late**, which is, 1 to 45 days after the end of the applicable statutory claims payment period.
Number of requests for verification received	Verify that the figure reported equals the sum of the figures for Number of Verifications Issued and Number of Declinations Issued. Please provide an explanation if the number of declinations plus the number of verifications issued doesn't equal the number of requests for verification.
Reporting "underpaid" claims	If an initial underpayment is made (and reported) and a subsequent additional payment is made in a different quarter, then the subsequent payment **must** be reported as a late payment as appropriate. If the subsequent payment is made outside the applicable statutory claims payment period, the carrier must reflect this in the report.

HB 610 quarterly report instructions

In 2001, TDI began collecting provider claims data from certain carriers in order to monitor compliance with HB 610 prompt pay requirements. SB 418 requires all licensed HMOs and insurers that write PPBPs to report data to TDI so TDI can determine compliance with SB 418 prompt pay requirements. However, SB 418 takes effect when carriers issue or renew their contracts with providers on or after August 16, 2003. Also SB 418 applies to claims for emergency care services, as well as services that were performed on referral from an HMO, PPBP, or a preferred provider because the services were not reasonably available in-network where the date of service is on or after August 16, 2003. For this reason, carriers will report contracts that were last issued or renewed prior to August 16, 2003, using the HB 610 format; for certain referral and emergency care claims, and claims for those contracts that have been issued or renewed after August 16, 2003, they will use the SB 418 format.

Additionally, each carrier that uses delegated entities to pay claims must report claims payment data from each of the carrier's delegated entities. Therefore, each carrier that uses delegated entities will complete and **submit a quarterly on-line data form for each delegated entity that processes a carrier's provider claims**. The data used to calculate the totals reported to TDI must be maintained for a minimum of three years and must be available for review by TDI. The retention of the data applies to a carrier's delegated entities as well.

HB 610 quarterly data entry screen

Reporting Year	2009
Reporting Period	Third Quarter

Number of Claims Received:	
Number of Claims Paid:	
Number of Clean Claims Received:	
Number of Clean Claims Paid:	
Number of Clean Claims Paid on or before the 45th day following receipt of claim:	
Number of Clean Claims Paid after the 45th day following receipt of claim:	
Number of Clean Claims Paid on day 46-59 following receipt of claim:	

Number of Clean Claims Paid on day 46-59 following receipt of claim:	
Number of Clean Claims Paid on day 60-89 following receipt of claim:	
Number of Clean Claims Paid on day 90 or later following receipt of claim:	
Number of Clean Claims Subject to Audit Paid at 85 percent following receipt of claim:	
Number of Claims Paid at Billed/Contracted Penalty Rate:	

SB 418 quarterly report instructions

SB 418 applies to provider claims under an HMO or insured PPBP plan for which the provider's contract was issued or renewed on or after August 16, 2003. SB 418 also applies to claims for emergency care services, as well as services that were performed on referral from an insurer, HMO, or preferred provider because the services were not reasonably available in-network where the date of service is on or after August 16, 2003.

As mentioned in conjuction with the HB610 data reports, any carrier that uses delegated entities to pay claims must report claims payment data from each of the carrier's delegated entities. Therefore, each carrier that uses delegated entities will complete and **submit a quarterly on-line data form for each delegated entity that processes a carrier's provider claims**. The data used to calculate the totals reported to TDI must be maintained for a minimum of three years and must be available for review by TDI. The retention of the data applies to a carrier's delegated entities as well.

The first boxes of the SB 418 quarterly data form indicate the reporting year and quarterly reporting periods. If the data being reported is not for the reporting year and quarter shown, please contact the Department to ensure that the correct quarterly report is unlocked for your data entry. The rest of the first page of the SB 418 quarterly data form includes boxes for data pertaining to **non-institutional providers**. The second page includes boxes for data pertaining to **institutional providers**. Carriers must separate claim payment information for institutional and non-institutional providers.

In addition, carriers must report the total number of claims received (this number includes deficient claims) and the total number of **clean claims** received (this number excludes deficient claims) during the reporting period. The deficient and clean claim data must also be separated by non-institutional and institutional providers, so carriers will complete these boxes on pages one and two accordingly. Once the totals have been entered, the rest of the boxes on page one and page two are for data on **clean claims only**. Again, page one is for non-institutional provider data and page two is for institutional provider data.

Carriers must report the number of clean claims paid **within** the applicable statutory claims payment period for electronically-adjudicated pharmacy, other electronic, and non-electronic claims. The applicable statutory claims payment period is:

- **18 days** for electronically-adjudicated pharmacy claims.
- **21 days** for non-electronic pharmacy claims.
- **30 days** for other electronic claims.
- **45 days** for non-electronic claims.

Carriers must also report the number of clean claims paid **late** (after the applicable statutory claims payment period for electronically-adjudicated pharmacy, other electronic and non-electronic claims). For clean claims that were paid **late**, carriers must report the number of clean claims that were paid:

- between 1 and 45 days after the end of the applicable statutory claims payment period (Electronic Pharmacy = days 19-63; Non-electronic Pharmacy = days 22- 66; Electronic = days 31-75; Non-electronic = days 46-90 following date of receipt).
- between 46 and 90 days after the end of the applicable statutory claims payment period (Electronic Pharmacy = days 64-108; Non-electronic Pharmacy = days 67- 111; Electronic = days 76-120; Non-electronic = days 91-135 following date of receipt).
- after the 91st day after the end of the applicable statutory claims payment period (Electronic Pharmacy = days 109+; Non-electronic Pharmacy = days 112+; Electronic = days 121+; Non-electronic = days 136+ following date of receipt).

The last page of the SB 418 quarterly data form applies to both clean and deficient claims. Carriers must report the total number of audited claims paid at 100 percent, the total number of requests for verifications the carrier received, the total number of verifications issued, the total number of declinations of verification requests, the total number of certifications of catastrophic events sent to TDI and the total number of business days that were interrupted due to catastrophic events.

In certain circumstances, claims will be reported in more than one quarter. Specifically, if an initial underpayment is made (and reported) and a subsequent additional payment is made in a different quarter, the subsequent payment **must** be reported as a late payment as appropriate. If the subsequent payment is made outside the applicable statutory claims payment period, the carrier must reflect this in the report.

Please read these instructions carefully before entering the SB 418 quarterly data. If you have questions regarding the information that must be reported to TDI, please send an email to promptpay@tdi.texas.gov.

SB 418 quarterly data entry screenshots

Reporting Year	2009
Reporting Period	Third Quarter

Non-Institutional Provider Data	
Number of Claims Received:	
Number of Clean Claims Received:	
Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid Late - between 1 and 45 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid Late - between 46 and 90 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid Late - on or after the 91st day after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Institutional Provider Data	
Number of Claims Received:	
Number of Clean Claims Received:	
Number of Clean Claims Paid within the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid Late - between 1 and 45 days after the end of the Applicable Statutory Claims Payment	

Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid Late - between 46 and 90 days after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Clean Claims Paid Late - on or after the 91st day after the end of the Applicable Statutory Claims Payment Period	
Pharmacy:	
Electronic:	
Non-Electronic:	
Number of Audited Claims Paid Pursuant to §21.2809:	
Number of Requests for Verification Received Pursuant to §19.1724:	
Number of Verifications Issued Pursuant to §19.1724:	
Number of Declinations Pursuant to §19.1724:	
Number of Certifications of Catastrophic Events Sent to TDI:	
Total Number of Days Business was Interrupted for Catastrophic Events:	

You are responsible for the accuracy of the data submitted. Please print this page now and immediately check for accuracy before clicking the submit button. If you are delayed in checking for accuracy, this page may "expire" and you will have to fill out the form again.

Clear/Start Over   Submit SB 418 Quarterly Data

Instructions for SB 418 annual reasons for declination of verifications report

Pursuant to TIC Sections 843.347 and 1301.133, carriers are required to provide verification of coverage. Carriers are required to report annually the reasons for declining to verify a claim, referred to as declinations. Carriers must also report declination data from all of the carrier's delegated entities. **Each carrier will complete and submit a SB 418 annual on-line data form for each delegated entity that processes that carrier's insureds' and/or enrollees' claims.** Additionally, carriers and their delegated entities, if applicable, must retain the data used to calculate the totals reported to the Department for a minimum of three years and must be available for review by the Department. The reporting period is from July 1st through June 30th. The report is due on **August 15th** of each year, along with the second quarter reports. The database application will not open this report up for data entry until the second quarter reporting begins.

SB 418 annual data entry screen

TDI CLAIMS DATA REPORTING

Enter SB418 Annual Declinations Data

LogOff

PLEASE NOTE

- If you do not represent the following company, please log out of this application, and immediately contact the Texas Department of Insurance.
- Please do not use the *Back* button in your browser, or you may lose data that you have entered.
- Required fields are preceded by a *

Company Legal Name: COMPANY1
TDI Company Number: 00000
NAIC Company Number: 11111

Reporting Year: 2008

CONFIDENTIALITY

* Company asserts that its responses hereto are proprietary and/or confidential.
Please note that your response to this question will affect how TDI would respond in the event it receives a request for this information pursuant to the Public Information Act, Texas Government Code, Chapter 552.
Yes
No

Field name	Tip
Reporting Year	The reporting year that is reflected in this field will be entered by the database. It will reflect last year, unless your are entering a late or amended report. For example: If you are entering data on August 15, 2009, the reporting year will be displayed will be 2008. Before entering data, please check to ensure that the data you are entering is for the reporting year shown. The reporting years run from July 1st through June 30th. If the data is for another year, please email us at PromptPay@tdi.state.tx.us to request your reporting form be unlocked.
Confidentiality	You must check either yes or no before the annual declination report will be accepted.

Company contact information

ENTER CONTACT INFO

* Contact Name	
* Contact Title	
* Direct Telephone Number (no dashes)	Area code: Number: Ext:
* Mailing Address - Street	
* City	
* State	
* Zip Code	-
* E-mail Address	
* TDI may release this e-mail address in response to a public information request.	Agree Do Not Agree

Field name	Tip
Contact name	Use this field to enter the name of the person that TDI may contact if there are questions regarding the data reported.
Title	Please enter the title of the contact person.
Direct telephone number	Please enter the direct telephone number of the contact person.
Mailing address	Please enter the mailing address of the contact person.
Email address	Please enter an email address for the contact person; don't enter a street address. If TDI staff members have questions about the data, they will contact this person.
TDI may release this email address in response to a public information request	This field requires you to provide an agree or do not agree response. Please indicate whether TDI may release the contact person's email address in response to a public information request.

Declinations for insurance policy or contract limitations

ENTER DECLINATIONS DATA FOR INSURANCE POLICY OR CONTRACT LIMITATIONS

* Number of Declinations Due to Premium Payment Time Frames that Prevent Verifying Eligibility for a 30-Day Period:
* Number of Declinations Due to Policy Deductibles, Specific Benefit Limitations or Annual Benefit Maximums:
* Number of Declinations Due to Benefit Exclusions:
* Number of Declinations Due to No Coverage or Change in Membership Eligibility, Including Individuals Not Eligible, Not Yet Effective, or Membership Cancelled:
* Number of Declinations Due to Pre-existing Condition Limitations:
* Number of Declinations Due to Other Policy or Contract Limitations:

If Other Policy or Contract Limitations, Please Explain:

(Please limit your comment to 4000 characters. If you wish to submit a longer comment about your data, please send it in an e-mail to promptpay@tdi.state.tx.us)

Field name	Tip
Number of declinations due to premium payment time frames that prevent verifying eligibility for a 30-day period	Enter the number of declinations of verifications that resulted from premium payment time frames that prevented verifying eligibility for a 30-day period.
Number of declinations due to policy deductibles, specific benefit limitations or annual benefit maximums	Enter the number of declinations of verifications that were a result of policy deductibles, special benefit limitations, or annual benefit maximums.
Number of declinations due to benefit exclusions	Enter the number of declinations of verifications that resulted from benefit exclusions.
Number of declinations due to no coverage or change in membership eligibility, including individuals not eligible, not yet effective or membership canceled	Enter the number of declinations of verifications that resulted from no coverage or a change in membership eligibility, including individuals not eligible, not yet effective or membership canceled.
Number of declinations due to pre-existing condition limitations	Enter the number of declinations of verifications that resulted from pre-existing condition limitations.
Number of declinations due to other policy or contract limitations	Enter the number of declinations of verifications that resulted from policy or contract limitation reasons other than previously specified. Use the next field to explain what those limitations are.
If other policy or contract limitations, please explain.	Explain the other policy or contract limitations that resulted in declinations of verifications.

Declinations due to inability to obtain necessary information

ENTER DECLINATIONS DUE TO INABILITY TO OBTAIN NECESSARY INFORMATION

* Number of Declinations Due to Lack of Information from the Requesting Physician or Provider:
* Number of Declinations Due to Lack of Information from Other Physician or Provider:
* Number of Declinations Due to Lack of Information from Any Other Person:
* Number of Declinations Due to Other Reasons:

If Other Reasons, Please Explain:

(Please limit your comment to 4000 characters. If you wish to submit a longer comment about your data, please send it in an e-mail to promptpay@tdi.state.tx.us)

SUBMIT DATA

By checking the box at right, you agree to be responsible for the accuracy of the data submitted. If you are delayed in checking for accuracy, this page may "expire" and you will have to fill out the form again.

Clear / Start Over | Submit SB418 Annual Data

Field name	Tip
Number of declinations due to lack of information from requesting physician or provider	Enter the number of declinations of verifications due to the inability to obtain information from the requesting physician or provider.
Number of declinations due to lack of information from other physician or provider	Enter the number of declinations of verifications due to the inability to obtain information from a physician or provider, other than the requesting physician or provider.
Number of declinations due to lack of information from any other person	Enter the number of declinations of verifications that resulted from an inability to obtain information from any other person (not a physician or provider.)
Number of declinations due to other reasons	Use this field to provide the number of declinations of verifications for any reason other than a policy/contract limitation or an inability to obtain information, please explain these reasons in the “other” box.
If other reasons, please explain.	Use this field to explain the reasons for the declinations of verifications if issued for any reason other than a policy/contract limitation or an inability to obtain information.