

Denial Prevention Checklist

Stop claim denials BEFORE they happen — check every item before submitting

A denied claim means delayed or lost payment. Most denials happen because of simple, avoidable mistakes. Use this checklist before submitting EVERY claim to catch errors early. A claim that passes all these checks has a much higher chance of being paid the first time.

PATIENT INFORMATION – Must Be 100% Accurate

-  **Patient name matches insurance card exactly ★**
Use the name on the insurance card — not a nickname. 'Robert' vs 'Bob' can cause a denial.
 -  **Date of birth is correct**
A single digit error in the birth date is one of the top reasons claims are rejected automatically.
 -  **Member ID number is correct**
Copy the member ID directly from the card. Do not type it from memory.
 -  **Insurance is active for the date of service**
Check eligibility for the EXACT date the service was provided, not today's date.
 -  **Correct insurance is listed as primary (if patient has two)**
Billing the secondary insurance first will result in an automatic denial.
-  *Wrong patient info is responsible for 20–30% of all claim denials. Double-check before hitting submit.*

PROVIDER INFORMATION – Your Practice Details

-  **Rendering provider's NPI number is correct ★**
The NPI is the provider's unique ID number. Wrong NPI = automatic denial.
-  **Billing provider's NPI and Tax ID are correct**
These identify your practice. They must match exactly what is on file with the payer.
-  **Provider is in-network for this patient's plan**
If the provider is out-of-network, check if the patient signed an out-of-network agreement.
-  **Provider credentials are up to date with this payer**
Expired credentialing = denied claims. Check credentialing expiration dates monthly.

CLAIM CODES – The Language of Billing

-  **CPT codes match what the provider actually did ★**
Read the provider's notes carefully. The CPT code must match the documentation exactly.

- **ICD-10 diagnosis code is valid and specific**
Use the most specific diagnosis code available. Unspecified or vague codes often get denied.
■ *Tip: Use a valid ICD-10 code lookup tool — codes change every October 1st.*

- **Diagnosis code supports the CPT code (medical necessity)**
The 'why' (diagnosis) must justify the 'what' (procedure). If they don't match, expect a denial.

- **Modifier codes are included if required**
Modifiers give extra information about a service. Missing a required modifier (like -25 or -59) causes many denials.

- **Units billed are accurate**
For timed services, make sure the number of units matches the actual time documented.

AUTHORIZATION & REFERRALS

- **Prior auth number is on the claim (if required) ★**
If the service needed prior auth, the approval number must be on the claim form.

- **Auth covers the exact date of service**
Auth that expired before the service date = denial. Always check the auth dates.

- **Referral is obtained if the patient has an HMO plan**
HMO plans almost always require a referral from the primary care provider for specialist visits.

■ *Keep copies of all auth approvals and referrals attached to the patient account record.*

CLAIM FILING – Final Checks Before Submission

- **Claim is being filed within the payer's deadline ★**
Most payers have a filing deadline (e.g., 90 days, 1 year from date of service). Filing late = automatic denial.

- **Place of service code is correct**
Was the service done in an office (11), hospital (21), telehealth (02)? Wrong code = denial.

- **Claim is clean — no missing required fields**
Run the claim through your billing software's scrubber tool before submitting to catch missing fields.

- **Duplicate claim check — this claim has not been submitted before**
Submitting a claim twice causes an automatic denial for the second submission.

Completed by:

Date: _____

Supervisor: _____