

Timely Filing Limits Reference Sheet

Submission deadlines by payer • How to prove timely filing • Tips to never miss a deadline

WARNING: Timely Filing Denials Are Almost Never Reversible Without Proof. Always document the date you submitted every claim.

Timely Filing means you must submit your claim to the insurance company within a set time limit after the date of service. If you miss this deadline, the claim will be denied and you generally cannot appeal — even if the service was legitimate and covered. The clock usually starts on the date of service (DOS), but some payers count from the date of discharge or the date the primary payer paid.

Major Payer Timely Filing Deadlines

Payer / Plan Type	Time Limit	In Days	Details & Notes
Medicare (Traditional / Fee-For-Service)	1 year (12 months) from date of service	365 days	From DOS or discharge date. If claim spans a year-end, use discharge date. CMS 1-year rule is firm. Proof of timely filing: clearinghouse confirmation report or MAC acknowledgment report.
Medicare Advantage (Part C) Plans	1 year from DOS (most plans)	365 days	Each MA plan sets its own deadline, but CMS requires a minimum of 1 year. Some plans enforce 90–180 days. Always check the specific plan's contract.
Medicaid — Federal Guideline	1 year from DOS (minimum standard)	365 days	Federal law requires states to accept claims up to 1 year from DOS. However, individual states may have SHORTER deadlines (e.g., 90 days). Check your state's Medicaid policy.
Blue Cross Blue Shield (BCBS) — Most Plans	90 days to 1 year	90–365 days	Varies by BCBS plan and state. Most BCBS plans require claims within 1 year, but some state plans enforce 90 or 180 days. Check the specific plan's Provider Manual.
UnitedHealthcare (UHC) — Commercial	90 days from DOS	90 days	One of the stricter commercial payers. UHC enforces 90 days for most commercial plans. Some UHC Medicare Advantage plans allow 365 days. Verify by plan type.
Aetna — Commercial	180 days from DOS	180 days	Aetna typically allows 180 days (6 months) for commercial claims. Aetna Medicare plans may allow 1 year. Check the specific plan certificate.
Cigna — Commercial	180 days from DOS	180 days	Cigna allows 180 days for most commercial plans. Some Cigna plans have a 90-day window. Cigna Medicare plans generally follow the 1-year Medicare rule.
Humana — Commercial	180 days from DOS	180 days	Humana commercial typically requires 180 days. Humana Medicare Advantage follows the 1-year CMS standard. Always verify with Humana's NaviNet portal or provider manual.
Tricare (Military Insurance)	1 year from DOS	365 days	TRICARE follows a 1-year timely filing rule from the date of service. For TRICARE For Life (TFL), the deadline is 1 year from Medicare's payment date.
Workers' Compensation	Varies widely — often 1 year	Varies	Each state has its own WC timely filing rules. Can range from 30 days to 3 years. Always check the state's WC regulations AND the specific WC carrier's guidelines.

Payer / Plan Type	Time Limit	In Days	Details & Notes
Medicaid — State Examples	See notes	30–365 days	CA Medi-Cal: 12 months TX Medicaid: 95 days NY Medicaid: 90 days FL Medicaid: 12 months IL Medicaid: 180 days OH Medicaid: 12 months. Always verify with your state's Medicaid agency.
Marketplace Plans (ACA/Exchange)	Generally 90–180 days	90–180 days	ACA marketplace plans are administered by commercial insurers. Deadlines vary by the insurer managing the plan. Treat like commercial insurance.

Color Guide:	RED = 90 days (act fast!)	GOLD = 180 days	GREEN = 365 days / 1 year	BLUE = Varies
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Timely Filing for Secondary Claims

Payer Type	Deadline	Key Notes
Medicare Secondary	1 year from DOS	Clock starts from the original date of service, NOT the primary payer's EOB date.
TRICARE For Life (TFL)	1 year from Medicare's payment	For TFL, the clock starts when Medicare pays — not from the DOS. Keep Medicare EOBs.
Commercial Secondary	Same as primary deadline OR 90–180 days from primary EOB	Many commercial plans start the clock from the primary EOB date. Some allow standard DOS counting.
Medicaid as Secondary	1 year from DOS (federal minimum)	Always submit Medicaid crossover claims promptly. Save the primary EOB as proof.
Auto Insurance / Liability	Varies by state — often 1–3 years	These are personal injury protection (PIP) claims. Refer to the state's auto insurance regulations.

How to Prove Timely Filing When a Claim Is Denied

Clearinghouse Acceptance Report	Your clearinghouse (Availity, Change Healthcare, etc.) generates a report showing the exact date and time your claim was submitted and accepted. This is your best proof. Save these reports automatically.
Electronic Remittance Advice (ERA / 835)	An ERA from a prior submission showing the claim was received and processed — even if it was denied — proves the claim was filed. Keep all ERAs.
USPS Certified Mail Receipt	For paper claims, send via USPS Certified Mail with Return Receipt. The green card and tracking number serve as legal proof of mailing date. Keep copies of the mailed claim and the receipt.
Payer's Own Acknowledgment	Some payers send a 277CA (claim acknowledgment) electronically. This document confirms receipt. Download and save 277CA reports from your clearinghouse.
Coordination of Benefits (COB) Letter	For secondary claims denied for timely filing, a letter showing the primary payer's slow processing can be used to justify a late submission. Attach the primary EOB dated after your deadline.

**Medical Records with
Date of Service**

In rare cases, complete medical records with the DOS can support an appeal if you can show the service occurred within the filing window. Always include this with your appeal letter.

Best Practices — Never Miss a Filing Deadline Again

- ✓ Set an internal filing policy shorter than the payer's deadline — bill all claims within 30 days of service.
- ✓ Use a clearinghouse that auto-saves acceptance reports and timestamps every submission.
- ✓ Run a weekly aging report to catch any claims not yet submitted or stuck in your billing queue.
- ✓ Train your front desk to collect accurate insurance info upfront — wrong payer info wastes valuable filing days.
- ✓ For workers' comp and state Medicaid claims, create a payer-specific cheat sheet of exact deadlines.
- ✓ If a payer processes slowly (e.g., long authorization review), resubmit early rather than waiting for approval.
- ✓ Keep all EOBs, ERAs, and clearinghouse reports in a secure archive for at least 7 years.
- ✓ Assign one person to monitor timely filing alerts in your practice management system.

For internal billing team use only • Always verify payer-specific rules • Codes subject to annual updates