PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION ____

MR. SPEAKER:

I move that House Bill 1461 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-8-5.7 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 5.7. Payment of Claims

Sec. 1. As used in this chapter, "insured" means an individual who is entitled to the benefits provided by a policy of accident and sickness insurance. The term includes the following:

(1) The policyholder of an individual policy of accident and sickness insurance.

(2) A member of the group covered by a group policy of accident and sickness insurance.

(3) An individual who is entitled to coverage under a policy of accident and sickness insurance as a spouse or dependent of an individual referred to in subdivision (1) or (2).

Sec 2. As used in this chapter, "insurer" means an entity issuing a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 4. (a) An insured who has received services from a provider that provides services, including emergency services, that an insurer is required to pay, is considered to have filed a proper and complete claim if the insured submits the following information:

(1) The name of the insured who received services.

(2) The address of the insured.

(3) The date of service.

(4) The Current Procedural Terminology (CPT) code.

(5) The International Classification of Diseases (ICD) disease classification.

(6) The name and address of the provider.

(7) Information on the insured's benefit card that is specific to the insured.

(8) Tax identification information of the provider.

(b) A claim for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) that meets the requirements under subsection (a) must be paid to the insured not more than fourteen (14) days after the claim is submitted.

(c) If a claim is not for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) the insurer may require the provider to submit information in addition to the information required under subsection (a). However, if a request for additional information under this subsection is not made within thirty (30) days after the insured has submitted a claim, the claim must be paid.".

Page 1, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 3. IC 27-13-36-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 9.5. (a) An enrollee who receives services from a provider that is not a participating provider and that provides services, including emergency services, that a health maintenance organization or a limited service health maintenance organization is required to pay a nonparticipating provider, is considered to have filed a proper and complete claim if the enrollee submits the following information:**

(1) The name of the enrollee who received services.

(2) The address of the enrollee.

(3) The date of service.

(4) The Current Procedural Terminology (CPT) code.

(5) The International Classification of Diseases (ICD) disease classification.

(6) The name and address of the provider.

(7) Information on the enrollee's benefit card that is specific to the enrollee.

(8) Tax identification information of the provider.

(b) A claim for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) that meets the requirements under subsection (a) must be paid to the enrollee not more than fourteen (14) days after the claim is submitted.

(c) If a claim is not for an evaluation and management code (as defined by the latest edition of the Current Procedural Terminology manual) the health maintenance organization or the limited service health maintenance organization may require the provider to submit information in addition to the information required under subsection (a). However, if a request for additional information under this subsection is not made within thirty (30)

days after the enrollee has submitted a claim, the claim must be paid.".

Renumber all SECTIONS consecutively.

(Reference is to hb 1461 as printed February 28, 2001.)

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Representative BROWN T