

APPENDIX G. PROMPT PAY FORM

PROMPT PAY FORM

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105
(405) 521-2828
(800) 522-0071 Toll Free (In State Only)
(405) 521-6632 Fax

**NOTE:
ENTITIES ACCUSED OF PROMPT PAY
VIOLATIONS ARE REQUIRED TO SUBMIT
DOCUMENTATION SUPPORTING THE REASON
FOR DELAY IN PAYMENT OR PROOF OF
PAYMENT TO THE OKLAHOMA INSURANCE
DEPARTMENT WITHIN TEN (10) DAYS.**

FROM: _____ Telephone: _____

Address: _____ City & State: _____ Zip: _____

Name of insured or member: _____ Telephone: _____

Address: _____ City & State: _____ Zip: _____

Full Name of Entity accused of
prompt pay violations: _____

Address: _____ City & State: _____ Zip: _____

Policy/Contract/Group Number or Name: _____

Dates Claims Originally Submitted: _____

Please give as detailed information as possible including dates and explain what solution you feel is correct. Attach copies of all correspondence relating to the inquiry. Include the following information if available: 1) Provider PIN such as health plan/company ID/tax ID; 2) Member ID number; 3) Date of original claim filing; 4) Date of service; 5) Billed amount for the service; and 4) description of the service or CPT code involved.

(Continue on the back)

**COMPLAINANT MUST PROVIDE A COPY OF THIS COMPLETED FORM TO THE ENTITY
ACCUSED OF PROMPT PAY VIOLATIONS AND THE OKLAHOMA INSURANCE
DEPARTMENT SIMULTANEOUSLY.**