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Clean Claim Starter Checklist

A practical pre-submission review for reducing avoidable claim errors, rejections, denials, and rework.

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A clean claim is one that includes the required patient information, provider information, payer details, coding, authorization, and documentation elements needed for the payer to process the claim without preventable delay, rejection, or denial.

Use this checklist before submitting a professional claim. Not every item applies to every claim. Review each section and complete what is relevant to the service, payer, plan, and practice workflow.

Note: Coding decisions, modifier use, authorization rules, payer edits, and documentation requirements vary. Always verify current payer rules, official coding guidance, official form instructions, clearinghouse edits, and your practice's internal policies before submission. This checklist is a general workflow reference — not coding, reimbursement, legal, or compliance advice.

Section 1 — Patient and Eligibility Verification

- ☐ Patient eligibility verified with the payer for the applicable date of service
- ☐ Front and back of the current insurance card collected and on file, if required by practice workflow
- ☐ Primary, secondary, and tertiary coverage confirmed
- ☐ Coordination of Benefits order documented
- ☐ Patient name spelling verified against current ID or payer record
- ☐ Patient date of birth verified
- ☐ Patient address and contact information reviewed
- ☐ Member ID confirmed
- ☐ Subscriber relationship confirmed
- ☐ Any inactive or outdated insurance policies removed or flagged in the practice management system
- ☐ Assignment of Benefits and other required patient financial forms signed and on file, if applicable

Section 2 — Provider and Claim Setup

- ☐ Rendering provider NPI reviewed for accuracy
- ☐ Billing provider NPI reviewed for accuracy
- ☐ Tax ID reviewed for accuracy
- ☐ Billing provider information matches payer enrollment records when applicable
- ☐ Billing address in Box 33 reviewed
- ☐ Rendering provider listed correctly
- ☐ Referring provider name and NPI present when required
- ☐ Place of service code matches the setting where the service was rendered
- ☐ Service facility information included when required

- ☐ Electronic payer ID is correct for the specific payer and plan
- ☐ Paper claims address reviewed if the payer does not accept electronic submission
- ☐ Rendering provider enrollment, credentialing, or participation status reviewed when relevant to the claim or payer

Section 3 — Prior Authorization and Dates

- ☐ Prior authorization confirmed as required or not required for this service and plan
- ☐ Authorization number entered in Box 23 if required
- ☐ Date of service falls within the authorization's valid date range
- ☐ Approved CPT or HCPCS codes on the claim match the codes listed on the authorization
- ☐ Units or visits billed do not exceed the authorized amount
- ☐ Provider or facility on the claim matches the authorization when required
- ☐ Referral information included when required
- ☐ Supporting authorization documentation saved or attached according to payer requirements

Section 4 — Coding and Diagnosis Review

> *Coding decisions should follow official coding guidelines, provider documentation, and payer-specific policies. This section is a general review prompt — not coding advice.*

- ☐ Every CPT or HCPCS code is linked to a supporting ICD-10 diagnosis code when required
- ☐ Diagnosis pointers reviewed for accuracy
- ☐ ICD-10 diagnosis codes are coded to the highest available level of specificity
- ☐ Primary diagnosis supports the medical necessity of the service billed
- ☐ All CPT, HCPCS, and ICD-10 codes are valid for the date of service
- ☐ Deleted or expired codes reviewed and corrected
- ☐ Gender-specific procedure codes reviewed against the patient's record
- ☐ Age-specific or diagnosis-specific payer edits reviewed when applicable
- ☐ Time-based procedure codes are supported by documented time in the clinical note
- ☐ Units are correct for the service rendered
- ☐ For J-codes or physician-administered drugs, units reflect the dosage administered
- ☐ NDC number attached or entered if required by payer
- ☐ CLIA number present on the claim for in-office laboratory tests, if required

Section 5 — Modifiers

> *Modifier use should follow current coding guidelines and payer-specific modifier policies. Verify requirements before applying.*

- ☐ Required modifiers are present for each applicable service line
- ☐ Modifier 25 reviewed when a distinct, separately identifiable E/M service was performed on the same day as a procedure

- ☐ Modifier 59 or applicable X-modifier reviewed for distinct procedures, according to payer policy and current NCCI guidance
- ☐ Telehealth modifier, such as GT or 95, applied when required by the payer
- ☐ Telehealth place of service and modifier combination reviewed against payer policy
- ☐ Global period reviewed for any recent surgical procedures before billing an E/M service
- ☐ Modifier order reviewed if multiple modifiers are applied
- ☐ Payer-specific modifier requirements checked before submission

Section 6 — Payer-Specific Requirements

- ☐ Payer coverage policy reviewed for the specific CPT or HCPCS codes being billed
- ☐ Payer reimbursement or billing policy reviewed when relevant
- ☐ Frequency limitations checked for preventive screenings or recurring services
- ☐ Clearinghouse ID is correct for this payer and branch
- ☐ Primary EOB attached for secondary claims when required
- ☐ Medicare crossover or secondary billing workflow reviewed when applicable
- ☐ Incident-to billing requirements reviewed per payer policy when mid-level provider services are billed
- ☐ HCPCS code used instead of CPT if the payer requires it for the service
- ☐ Records or attachments included when required
- ☐ Original claim reference number included for corrected claims when required
- ☐ Correct frequency code used for corrected or voided claims when applicable
- ☐ Known recurring denial patterns for this payer reviewed before submission

Section 7 — Final Pre-Submission Scrub

- ☐ Claim scrubber or clearinghouse pre-edit report reviewed
- ☐ All claim scrubber errors addressed
- ☐ All claim scrubber warnings reviewed
- ☐ Missing required fields corrected
- ☐ Zip codes reviewed
- ☐ Dates reviewed
- ☐ Provider information reviewed
- ☐ Diagnosis pointers reviewed
- ☐ Claim form reviewed for completeness before submission
- ☐ Submission method confirmed: electronic, paper, portal, or other payer-required method
- ☐ Timely filing deadline reviewed when submitting, correcting, or resubmitting an older claim
- ☐ Attachments included when required
- ☐ Secondary claim information reviewed when applicable
- ☐ Correct payer order confirmed
- ☐ Duplicate claim risk reviewed before submission
- ☐ Submission documented with date and method for tracking
- ☐ Claim acceptance or rejection report checked after submission

QUICK SUMMARY

Section	Key Focus
Patient and Eligibility Verification	Active coverage, demographics, insurance card, COB order, patient forms
Provider and Claim Setup	NPI, Tax ID, POS, credentialing, payer enrollment, payer ID
Prior Authorization and Dates	Authorization number, valid dates, approved codes, units, referral requirements
Coding and Diagnosis Review	Valid codes, specificity, diagnosis support, units, documentation
Modifiers	Required modifiers, telehealth rules, global periods, payer-specific modifier policies
Payer-Specific Requirements	Coverage rules, frequency limits, crossover claims, attachments, corrected claim details
Final Pre-Submission Scrub	Clearinghouse edits, final field review, timely filing, submission tracking

RECOMMENDED RELATED FORMS

The following free forms are available at MedicalBillingForms.com:

- Clean Claim Checklist — detailed field-by-field pre-submission review for CMS-1500 professional claims
- CMS-1500 Preparation Checklist — Box-by-box checklist covering every required field on the CMS-1500 form
- Insurance Verification Form — structured form for documenting eligibility and benefit verification results
- Prior Authorization Request Checklist — gather all required information before submitting an authorization request
- EOB Review Checklist — step-by-step checklist for reviewing EOBs and identifying denial lines after adjudication
- Denial Follow-Up Tracker — structured log for tracking denied claims from denial date through resolution
- Claim Correction Worksheet — document what changed between the original claim and the corrected resubmission