

Claim follow up guide

Accepted is not a payment decision

Confirm payer acceptance, capture the payer claim number when available, and set a follow-up date using the applicable payer and plan rules. A1 indicates receipt; A2 indicates acceptance into adjudication. Neither proves payment. [1, 2]

Missing number or A4 status

A missing number does not prove the claim was never received. A4 means not found in the adjudication system. Verify search details, payer, patient identifiers, dates of service and routing. Reconcile conflicting acceptance evidence with the payer or clearinghouse before resending. [1, 2]

Who needs to act

P1: in process. P2: payer review. P5: payer administrative or system hold. P3: information has been requested from the provider. P4: information has been requested from the patient. Read the detailed status and the actual request; assign the next action to a named owner. [2]

Know which clock you are tracking

Original Medicare clean-claim payment status: CMS says wait at least 14 days for electronic claims or 29 days for paper claims. Confirm receipt and handle requests earlier. Commercial and Medicaid rules vary by plan and jurisdiction. Track filing, documentation and appeal deadlines separately. [1]

Requests and returned claims

Original Medicare prepayment medical review requests generally allow 45 calendar days for MAC reviews and 30 for UPIC reviews; follow the actual notice. Medicare MA130 identifies an unprocessable return without appeal rights for that return. Correct and submit as instructed. A4 and MA130 are different situations. [3, 4]

Resolve the task only after the outcome is verified

F1, F2 and F4 report finalized payment, denial or no further payment. Review the remittance and affected service lines; reconcile payment or route the remaining balance for the right next action. A finalized status alone does not establish that the account is fully resolved. [2]

Sources

1. CMS - Checking Medicare Claim Status (March 2026)
2. X12 - Claim Status Category Codes
3. CMS - Additional Documentation Request
4. First Coast - Claims Returned as Unprocessable

Claim follow up log

Use an approved, access-controlled location. Account and claim numbers can still identify a patient. Record only what your organization permits.

One row per follow-up item. Record the claim or line scope and keep submission and acceptance evidence.

Account ref Claim / line	Payer / plan	Sent / accepted	Payer claim # Status / date	Request / deadline	Action owner	Next action / evidence	Follow-up date	Outcome / handoff

Emphanex practice method

Assign an owner and a dated next action. Review unresolved items on a risk-based schedule; escalate overdue requests and approaching filing limits. Reconcile outcomes or document a handoff before closing the item. These workflow steps are not payer rules.

Accepted is not approved. Quiet is not paid.

I'll see you on the path.