Medical Claims Data Submission Guide

Microsoft Excel is the preferred format (if applicable). Please send all information to **stoplossmail@hmig.com**

Claimant ID
Claimant Last Name
Claimant First Name
Claimant Middle Initial
Claimant Date of Birth
Claimant Gender
Claimant Relationship
Division / Class / Location (if applicable)
Claim Number
Service Date From
Service Date Through
Received Date
Paid Date
Procedure Code
Procedure Modifier
Procedure Code Description
Diagnosis Code

Diagnosis Code Description
Revenue Code
Revenue Code Description
Benefit Code (if utilized by TPA)
Benefit Code Description
Patient Admission Date
Patient Discharge Date
Billed Amount
Coinsurance Amount
Copayment Amount
Deductible Amount
Allowed Amount
Paid Amount
Provider Number
Provider Name
Provider City / State
Network Provider (if applicable)

For more information, contact your HM Regional Sales Office or visit **hmig.com**

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MTG-3097 (R1/18)