



General Assembly

**Amendment**

February Session, 2026

LCO No. 4256



Offered by:

REP. WOOD K., 29<sup>th</sup> Dist.

REP. PAVALOCK-D'AMATO, 77<sup>th</sup> Dist.

To: Subst. House Bill No. 5377

File No. 245

Cal. No. 201

**"AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER  
PAYMENTS AND SITE OF SERVICE BILLING REQUIREMENTS."**

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- 1 In line 7, strike "fifteen" and insert in lieu thereof "twelve"
- 2 In line 44, strike "twelve" and insert in lieu thereof "thirty"
- 3 Strike section 2 in its entirety and renumber internal references
- 4 accordingly
- 5 After the last section, add the following and renumber sections and
- 6 internal references accordingly:
- 7 "Sec. 501. (NEW) (*Effective January 1, 2027*) (a) For the purposes of this
- 8 section, "health care provider" has the same meaning as provided in
- 9 section 38a-477aa of the general statutes.
- 10 (b) (1) No insurer, health care center, fraternal benefit society,
- 11 hospital service corporation, medical service corporation or other entity
- 12 delivering, issuing for delivery, renewing, amending or continuing an

13 individual or group health insurance policy in this state on or after  
14 January 1, 2027, providing coverage of the type specified in subdivisions  
15 (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, shall  
16 cancel, deny or demand the return of full or partial payment for an  
17 authorized covered service due to administrative or eligibility error,  
18 more than twelve months after the date of the receipt of a clean claim  
19 for such service, except if:

20 (A) Such insurer, center, society, corporation or other entity has a  
21 documented basis to believe that such claim was submitted fraudulently  
22 by such health care provider;

23 (B) The health care provider did not bill appropriately for such claim  
24 based on the documentation or evidence of what medical service was  
25 actually provided;

26 (C) Such insurer, center, society, corporation or other entity has paid  
27 the health care provider for such claim more than once;

28 (D) Such insurer, center, society, corporation or other entity paid a  
29 claim that should have been or was paid by a federal or state program;  
30 or

31 (E) The health care provider received payment for such claim from a  
32 different insurer, payor or administrator through coordination of  
33 benefits or subrogation, or due to coverage under an automobile  
34 insurance or workers' compensation policy. Such health care provider  
35 shall have one year after the date of the cancellation, denial or return of  
36 full or partial payment to resubmit an adjusted secondary payor claim  
37 with such organization on a secondary payor basis, regardless of such  
38 insurer's, center's, society's, corporation's or other entity's timely filing  
39 requirements.

40 (2) (A) Such insurer, center, society, corporation or other entity shall  
41 give at least thirty days' advance notice to a health care provider by  
42 certified mail, return receipt requested, electronic mail to such electronic  
43 mail address designated by such health care provider or facsimile, or

44 through a secure electronic health care provider portal or electronic  
45 clearinghouse used for claims or remittance communications, of the  
46 insurer's, center's, society's, corporation's or other entity's cancellation,  
47 denial or demand for the return of full or partial payment pursuant to  
48 subdivision (1) of this subsection.

49 (B) If such insurer, center, society, corporation or other entity  
50 demands the return of full or partial payment from a health care  
51 provider, the notice required under subparagraph (A) of this  
52 subdivision shall disclose to the health care provider (i) the amount that  
53 is demanded to be returned, (ii) the claim that is the subject of such  
54 demand, and (iii) the basis on which such return is being demanded.

55 (C) Not later than thirty days after the receipt of the notice required  
56 under subparagraph (A) of this subdivision, a health care provider may  
57 appeal such cancellation, denial or demand in accordance with the  
58 procedures provided by such insurer, center, society, corporation or  
59 other entity, which shall include, but need not be limited to, an  
60 electronic appeal process. If any such insurer, center, society,  
61 corporation or other entity fails to notify the health care provider of such  
62 insurer's, center's, society's, corporation's or other entity's determination  
63 of such appeal not later than thirty business days after receipt of such  
64 appeal from such health care provider, such appeal shall be construed  
65 in favor of such health care provider. Any demand for the return of full  
66 or partial payment shall be stayed during the pendency of such appeal.

67 (D) If there is no appeal or an appeal is denied, such health care  
68 provider may resubmit an adjusted claim, if applicable, to such insurer,  
69 center, society, corporation or other entity, not later than thirty days  
70 after the receipt of the notice required under subparagraph (A) of this  
71 subdivision or the denial of the appeal, whichever is applicable, except  
72 that if a return of payment was demanded pursuant to subparagraph  
73 (C) of subdivision (1) of this subsection, such claim shall not be  
74 resubmitted.

75 (E) A health care provider shall have one year after the date of the

76 written notice set forth in subparagraph (A) of this subdivision to  
77 identify any other appropriate insurance coverage applicable on the  
78 date of service and to file a claim with such insurer, center, society,  
79 corporation or other issuing entity, regardless of such insurer's, center's,  
80 society's, corporation's or other issuing entity's timely filing  
81 requirements."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	<i>January 1, 2027</i>	New section