



Claim Clarity
ACADEMY

BY CLAIM CLARITY CONSULTING

The 5 Minute Denial First Look Checklist

10 questions before you correct, appeal, or escalate

Use this checklist during the first few minutes of review. Mark Yes when information is confirmed, No when the answer reveals a gap, and Not Yet when more evidence is needed.

Any No or Not Yet response is a signal to pause before choosing the recovery route.

Privacy first

Keep this external learning tool de-identified. Do not enter patient names, dates of birth, medical record numbers, member IDs, claim numbers, or other protected or confidential information.

Clearer claims. Stronger revenue.

The 10 question first look

1 What happened to the claim?

Decide whether the issue is a rejection, edit, denial, underpayment, or still unclassified. Do not choose a recovery route until the issue type is clear.

☐ Yes ☐ No ☐ Not Yet

2 What exactly did the payer report?

Read the ERA or EOB and record the payer message, including the CARC, RARC, edit message, or payment explanation that applies.

☐ Yes ☐ No ☐ Not Yet

3 Did the claim reach adjudication?

Confirm whether the payer actually processed the claim. A front-end rejection or edit usually follows a different path than an adjudicated denial.

☐ Yes ☐ No ☐ Not Yet

4 What is the response deadline?

Verify the current correction, reconsideration, appeal, or dispute deadline before doing anything else. Record the source used to confirm it.

☐ Yes ☐ No ☐ Not Yet

5 What evidence supports the next step?

Review the submitted claim, eligibility, authorization, documentation, coding rationale, payer policy, contract, or payment history as applicable.

☐ Yes ☐ No ☐ Not Yet

The 10 question first look

6 Is the payer message the root cause?

Separate what the payer reported from the workflow condition that allowed the issue to occur. They may be related, but they are not always the same.

☐ Yes ☐ No ☐ Not Yet

7 Which recovery route fits?

Choose only after reviewing current payer instructions: correction/resubmission, reconsideration, formal appeal, payment dispute, escalation, or more investigation.

☐ Yes ☐ No ☐ Not Yet

8 Who owns the action and follow-up?

Assign one person or team, a specific next action, and a follow-up date. Avoid notes that end with “researching” and no accountable next step.

☐ Yes ☐ No ☐ Not Yet

9 Could the same issue happen again?

Identify the upstream control gap, handoff, system rule, training need, or payer behavior that should be reviewed for prevention.

☐ Yes ☐ No ☐ Not Yet

10 How will this be categorized for trending?

Use a consistent category so repeated issues can be measured by payer, location, service, cause, team, or other meaningful reporting dimension.

☐ Yes ☐ No ☐ Not Yet

Choose the next lane

Rejected or stopped before adjudication

Correct the applicable data or workflow issue and follow current clearinghouse or payer resubmission instructions.

Adjudicated denial

Review the remittance, evidence, policy, appeal rights, and filing limit before choosing correction, reconsideration, or appeal.

Underpayment or payment variance

Compare payment with the contract, fee schedule, pricing method, and claim details before disputing or escalating.

Still unable to classify

Pause and confirm claim status, submission history, remittance information, and processing details.

Before you close the first look

- ☐ Deadline confirmed from a current source
- ☐ Next action has an owner and follow-up date
- ☐ Note explains the evidence and reasoning
- ☐ Issue has a consistent trend category
- ☐ No protected information appears in this checklist

Ready to go deeper?

Denial Management and Root Cause Analysis: From Denial to Prevention builds the repeatable assessment, root-cause, ownership, and prevention skills behind this quick first look.

Learn more at claimclarityconsulting.health

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