The Procedure for Submitting a Health Insurance Claim for Health Fund Solution Products at PT. XYZ

Asrori [1] , Windri Nabila Safitri [2]
[1]Program Pendidikan Vokasi , Administrasi Asuransi dan Aktuaria, Universitas Indonesia
[2]Program Pendidikan Vokasi UI, Kecamatan Beji, Kota Depok, Jawa Barat 16424
Correspondence: drs.asrori2@gmail.com
windrinabilasafitri@gmail.com

Abstract. Claims in insurance are a process where participants get their rights through a policy agreement. The submission of health claim insurance is carried out with a deal that has been agreed upon from the beginning. This study discusses filing a health insurance claim for Health Fund Solution products at PT. XYZ. This study uses primary data with descriptive methods to explain and describe various things related to the procedures for submitting health insurance claims that apply to PT XYZ. Guidelines for submitting a health insurance claim to an insurance company start from the participant's submission to the insurance and the claim analysis process until the decision on the claim being submitted is postponed, rejected, or accepted.

Keywords: *Claims, Policies, Health Insurance, Filing Procedures*

1 Introduction

Humans in their lives are always uncertain and try to replace that uncertainty with maximum certainty with insurance, replace uncertainty with economics, and financial uncertainty into financial certainty; all this uncertainty is called risk.

With this insurance agreement, humans can be relieved from the risks that may occur to their lives, health, goods/properties. This risk transfer does not just happen without any obligation from the transferor. This must be agreed upon in advance. In return for this risk transfer, premium payment is a must in the insurance agreement. Premiums are an obligation for the insured and become the rights of the insurer.

Insurance is a non-bank financial institution that has a role that is not much different from a bank, which is engaged in services provided to the public in overcoming risks that occur in the future. Insurance regulations in Indonesia regulated in the Law of the Republic of Indonesia No. 40 of 2014 concerning the Insurance Business.

D. V. Ferezagia et al. (eds.), *Proceedings of the International Conference on Vocational Education Applied Science and Technology (ICVEAST 2023)*, Advances in Social Science, Education and Humanities Research 783,
https://doi.org/10.2991/978-2-38476-132-6_2

Health insurance is the basis of health financing that comes from the public sector or the private sector. Public sector insurance can be in the form of social insurance, namely BPJS (Social Health Insurance Administration Body). While private insurance is in the form of health insurance managed by private parties or business entities

Everyone has the right to obtain their rights based on the agreed agreement. Insurance companies give their best efforts to guarantee the rights of each participant. This process is part of the insurance claim.

2 Material and Methods

2.1 Material

Health Insurance. Health insurance is insurance that guarantees to overcome risks in financing and health care. The ownership of health insurance consists of the government or the private sector, both of which aim to enable the public to have health service facilities Health insurance aims to transfer the risk of illness costs from the insured to the insurer so that the insurer must provide costs or health care services to the insured if he is sick.

Insurance Policy. The policy is a document containing an agreement between the parties, the insured and the insurer (insurer), for the risk to be accounted for. The policy is proof of the closing agreement

Insurance Claim. A claim is an application of rights made by the insured to the insurer to get his rights in the form of coverage for losses based on the agreement or contract that has been made. In other words, a claim is a process submission by participants to get the sum assured. There are 3 (three) stages in an insurance claim, namely:

1. Notifications

   Regarding the deadline for reporting claims, 30, 60, and 90 days are by the policy provisions. The insured reports to the insurance company in writing (verbal)

2. Investigation

   I found facts about events that occurred by conducting surveys or coming to the location. Request several documents of proof of the value of the loss and others.

3. Submission

   The Insured sends supporting documents for the claim requested by the insurer. The insurer checks the document's suitability to the policy, completes the documents requested by the insurer and sends it to the insurer.

2.2 Data and Method

The data used in this study consisted of two types, namely:

1. Primary Data.

Primary data was obtained from the results of the employee interviews claims section.

2. Secondary Data.

   Secondary data is obtained from claim files submitted by the Insured or the Insurance Policy Holder. The research method is a descriptive research method carried out by taking several steps, namely collecting, analyzing, and making conclusions that aim to accurately describe the procedure for submitting health insurance claims for health fund solution products at PT XYZ

3 Results

The following is an explanation of the process for submitting an insurance claim for Health Fund Solutions at PT XYZ:

1. Submitting an insurance claim, the Policy Holder or the insured submits his claim directly to PT XYZ.
2. Filling out the insurance claim form, the policyholder or the insured downloads (downloads) the claim form that is already available on the website or takes it to the branch office that provides the claim form along with instructions and required documents to the insured submitting the claim.
3. Submit a claim submission form; after filling in the claim submission file, the policyholder or the insured must send the claim submission file and supporting documents to the head office or nearest branch office of PT XYZ.
4. Receipt of documents by the mailing room and document Centre team, documents sent by the policyholder or the insured will be received by the mailing room then the mailing room will distribute the documents to the claim unit through the document Centre. Furthermore, the submission of claims that the document Centre team has received will be registered according to the submission type. Documents that have been registered will be distributed to the analyst team for the analysis process and verification of the completeness of the documents.
5. Check the completeness of the documents, the claim submission documents that the analyst team has received from the document Centre will then be verified or checked according to the requirements of the claim submission document to determine whether it is by the provisions required in the insurance claim submission process, After receiving notification of the existence of submission of claims from customers or policyholders, in this case the analyst team conducts inspections in the form of policy activity, fills out claim analysis forms, completes documents, claims verification and claims decisions.
6. Claim Advanced Verification, If the documents are complete but have not been paid, the analyst claim team will submit them to the investigation system and

coordinate with the related unit (investigation team) to carry out further verification by taking into account the following:
   a. Investigate whether the claim is suspicious or not
   b. Confirm the correctness of the treatment carried out by the customer to the relevant hospital.
   c. Investigating the crime scene
   d. If you find any discrepancies, the claim can be rejected
7. Payment process (approval) for insurance claims, After analysis by the analyst claim team or another verification process, if it is completed, the claim submission will be checked or re-checked by the coordinator or assistant manager. If the document is eligible for payment, it enters the approval stage, which the company's superiors will approve with the following conditions:
   1. Assistant Manager: under Rp. 10,000,000
   2. Manager: above Rp. 10,000,000 – Rp. 250,000,000

for transferring funds to customers, it will be automatically paid through the implied H+1 system after the approval date by the assistant manager and manager.

4 Discussion

Claim Submission Stages result in different claim decisions. Several possible Claim Decisions have occurred, namely:

1. Claim Submission is Pending.
   The claim is postponed if the customer is submitting a claim there is still a lack of documents, then the company will inform you about the lack of documents that must be completed to process claim payments. If all documents are complete and fulfilled, then the claim is eligible to be paid. Claims deferred are divided into two, namely:
   a. Postponed completeness (pending completeness)
   b. Delayed verification (pending verification).

   Pending Verification is a pending claim for further verification for suspicious customers.
2. Claim Submission Denied.
   If claim data is found that does not match the facts in the field (an investigation has been carried out), the claim will, of course, be rejected. However, claims rejected not only occur during an investigation; there are several other causes for claims being rejected, including:
   a. Expired Claims, Claims that have passed the deadline for submission, which is more than 60 (sixty) days since the treatment has been given

b. Lapsed Policy, Termination of insurance coverage as a result of non-payment of premiums and policy fees that are due
c. Pre Existing Claims, Claims which, if treated, are required for the policy age to have passed 12 months, with a diagnosis that includes a waiting period.
d. Fraud Claims, Claims that are proven to have not carried out maintenance and fraud.

3. Claim Submission Accepted.
   In the process of making a health insurance claim for a health fund solution product, take the following steps:
   a. Receive claim submission files from customers, mailing room and document centre. The received data is entered (input data) into the iClips system.
   b. The analysis and verification process is carried out, such as policy activity, proof of premium payment, filling out claim forms, and claim verification and completeness of documents that PT XYZ has required,
   c. If the claim verification is fulfilled or appropriate, further verification will be carried out at the customer's location or the hospital where the customer is receiving treatment. If the customer is suspicious, the investigation team confirms the truth of the customer taking care of the relevant hospital. Then the investigation team also confirmed with the doctor who handled the customer.
   d. If the verification process runs smoothly, there are no problems, and the customer is proven correct for the treatment, then the company has no reason to reject the claim. Next, the claim analyst team immediately processes the claim, and PT XYZ has a standard claim processing process for 14 (fourteen) working days to settle every claim that comes in with the requirements that have been met.
   e. Determine the people entitled to receive the benefits of the policy then paid to the customer whose name is listed in the policy.

5 Conclusion

The procedure for submitting a health insurance claim provided by the insurer starts with the participant's submission to insurance, the claim analysis process, and the decision of the claim being submitted. Namely, there is a delay, rejection or acceptance. Submission of health insurance claims and completing the submission procedure in completing the health insurance claim files on time has been determined will result in a claim decision being accepted and the amount of claim payment being appropriate.

References

1. J. Prakoso, Asuransi di Indonesia, Semarang: Dahara Prize, 1989.
2. O. J. K. (OJK), "UNDANG-UNDANG REPUBLIK INDONESIA NOMOR 40 TAHUN 2014 TENTANG PERASURANSIAN," Otoritas Jasa Keuangan (OJK), 2014. [Online]. Available: https://www.ojk.go.id/id/kanal/iknb/regulasi/asuransi/undang-undang/Documents/Pages/Undang-Undang-Nomor-40-Tahun-2014-Tentang-Perasuransian/UU%20Nomor%2040%20Tahun%202014.pdf. [Accessed 10 September 2022].
3. M. S. Sulla, Asuransi Syariah Life and General Konsep dan Operasional, Jakarta: Gema Insani Press, 2004.
4. P. Arimbawa, "HUBUNGAN KEPEMILIKAN ASURANSIKESEHATAN DENGANPENGGUNAAN OBAT RASIONAL (POR) PADA PASIEN SWAMEDIKASI.," *Jurnal Ilmiah Medicamento,* vol. 4, no. No. 2, pp. 118 - 122, 2018.
5. Sunarmi, "PEMEGANG POLIS ASURANSI DAN KEDUDUKAN," *JURNAL ILMU HUKUM,* vol. 3, no. 1, 2012.
6. A. Amrin, "Asuransi Syariah Keberadaan dan Kelebihannya di Tengah Asuransi Konvesional," PT Elex media komputindo, Jakarta, 2006.
7. S. Handayani, "PENGARUH PENYELESAIAN KLAIM ASURANSI TERHADAP PENCAPAIAN TARGET PENJUALAN," *Ekombis Review,* vol. 5, no. 1, pp. 79 - 85, 2017.
8. A. Heryana, Buku Ajar: Asuransi Kesehatan dan Managed Care, Jakarta: Universitas Esa Unggul, 2021.