2026 Timely Filing Limits by Payer

Initial claims, corrected claims, appeals and secondary deadlines on one page. Initial limits run from the date of service unless noted.

A-Z Medical Billing
a-zmedicalbillingandconsulting.com
Built inside a four-location practice

INITIAL CLAIM FILING LIMITS

from date of service

Medicare Part B	12 months	Corrected claims share this window; a rejection does not reset it
Medicare Advantage	6 to 12 mo	UHC MA 365, Humana MA 365, Aetna MA 180
Medicaid (by state)	90 to 365 d	HI 180, CA 180, TX 95, NY 90, FL 365
UnitedHealthcare	90 days	In-network and out-of-network
Aetna	90 days	In-network; out-of-network per plan
BCBS / Anthem	180 days	Varies by licensee: BCBS IL 365, BCBS TX 95
Cigna	180 days	Some plans extend to 365
Humana (commercial)	180 days	Medicare Advantage 365
Tricare	365 days	Tricare for Life: 365 from Medicare EOB when Medicare is primary
VA Community Care	180 days	
Centene / Ambetter	90 to 180 d	Marketplace plans typically 90 to 120
Molina	90 to 180 d	Medicaid follows state; marketplace typically 180
Workers' comp (by state)	Varies	HI 24 mo from DOS or 12 mo from injury report; CA 180 days
OWCP (federal)	12 months	

CORRECTED AND SECONDARY CLAIMS

Medicare corrected	12 mo DOS	Original window only
Commercial corrected	60 to 90 d	From rejection date or original deadline, whichever is later. UHC and Aetna count from rejection
Secondary after Medicare	90 to 180 d	From the Medicare EOB or ERA date
Retroactive eligibility	90 days	From the date the change was communicated
COB delay	Extended	When the wait on the primary payer is documented

APPEAL DEADLINES

from denial, EOB or ERA

Medicare Part B	120 d	Redetermination. Reconsideration 180 d after; ALJ 60 d
UnitedHealthcare	90 d	Second level 60 d from reconsideration
Aetna	90 d	Second level 60 d; pre-service appeals before the service
BCBS / Anthem	180 d	Second level 60 d
Cigna	180 d	Second level 60 d
Humana	180 d	Second level 60 d
Tricare	90 d	Formal review 60 d from reconsideration
Workers' comp	Varies	State boards. HI 60 d via DLIR

PAST THE DEADLINE? CHECK THESE BEFORE WRITING OFF

- **Retroactive eligibility.** The clock may start when eligibility was confirmed, not at the date of service.
- **Coordination of benefits.** If the delay came from waiting on the primary payer, appeal with the primary EOB attached.
- **Payer or clearinghouse errors.** Outages and EDI rejections count as cause. Keep screenshots and transmission reports.
- **Retroactive provider enrollment.** Gap-period claims run from the enrollment effective date.
- **Declared emergencies.** CMS and some payers extend deadlines. Check current bulletins.

Four clocks, four start dates. Initial claims run from the date of service. Appeals run from the denial. Corrected claims at most commercial payers run from the rejection. Secondary claims run from the primary payer's EOB. A timely filing appeal fails without proof of submission, so keep every clearinghouse transmission report with its date and confirmation number.

The claims that expire are the ones nobody is watching. A-Z flags every unanswered claim at 45 days and escalates at 60, by payer and by location, so a deadline never passes quietly. Free revenue leak analysis for multi-location groups: a-zmedicalbillingandconsulting.com/group-practices/

Verify against the payer's current provider manual before relying on a limit. Payer policies change, and plan-level contracts override published defaults. Updated October 2026.