**67:16:35:04.  Time limits for submission of claims.** The department must receive a provider's completed claim form within six months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

 (1)  The claim is an adjustment or void of a previously paid claim and is received within three months after the previously paid claim;

 (2)  The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;

 (3)  The claim is received within three months after a previously denied claim;

 (4)  The claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or

 (5)  To correct an error made by the department.

 **Source:** SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 2, effective July 17, 1988; transferred from § 67:16:01:14, 17 SDR 4, effective July 16, 1990; 19 SDR 26, effective August 23, 1992; 37 SDR 53, effective September 23, 2010.

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