(3) WHEN THE LEGITIMACY OR APPROPRIATENESS OF THE HEALTH CARE SERVICE IS DISPUTED, AN INSURER MAY REQUEST ADDITIONAL MEDICAL INFORMATION THAT DESCRIBES AND SUMMARIZES THE DIAGNOSIS, TREATMENT, AND SERVICES RENDERED TO THE INSURED.

(4) WHEN NECESSARY TO DETERMINE ELIGIBILITY FOR BENEFITS OR FOR DETERMINATION OF COVERAGE, AN INSURER MAY OBTAIN ADDITIONAL INFORMATION FROM ITS INSURED, THE EMPLOYER OF THE INSURED, OR ANY OTHER NON-PROVIDER THIRD PARTY, PROVIDED THAT ANY DELAYS IN PAYING A UNIFORM CLAIM RESULTING FROM OBTAINING THIS INFORMATION ARE SUBJECT TO THE PROVISIONS OF SUBSECTION (B)(2)(II)2 OF THIS SECTION.

~~(4)~~ (5) THE COMMISSIONER MAY IMPOSE A PENALTY NOT TO EXCEED $500 ON ANY INSURER THAT VIOLATES THE PROVISIONS OF THIS SECTION.

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(F) (1) FOR SERVICES RENDERED BY ANY PERSON ENTITLED TO REIMBURSEMENT UNDER SUBSECTION (A) OF THIS SECTION OR A HOSPITAL AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL ARTICLE:

(I) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, AN INSURER SHALL ACCEPT THE UNIFORM CLAIMS FORM ADOPTED BY THE INSURANCE COMMISSIONER UNDER § 490P OF THIS ARTICLE:

1. AS A PROPERLY FILED CLAIM WITH ALL NECESSARY DOCUMENTATION; AND

2. AS THE SOLE INSTRUMENT FOR REIMBURSEMENT; AND

(II) AN INSURER MAY NOT IMPOSE AS A CONDITION OF REIMBURSEMENT ANY REQUIREMENTS TO:

1. MODIFY THE UNIFORM CLAIMS FORM OR ITS CONTENT; OR

2. SUBMIT ADDITIONAL CLAIMS FORMS.

(2) THE UNIFORM CLAIMS FORM SUBMITTED UNDER THIS ~~PARAGRAPH~~ *SUBSECTION*:

(I) SHALL BE PROPERLY COMPLETED; AND

(II) MAY BE SUBMITTED BY ELECTRONIC TRANSFER.