

Request to Commissioner for Independent Review of Disputed TennCare Claim

Please complete this form and fax or mail it back to us. You will be copied on our correspondence concerning this matter. Please provide documentation that supports your complaint.

DO **NOT** send any Member Protected Health Information (PHI) via email unless you have HIPAA compliant encrypted email. PHI includes the members name and other demographic information.

Complainant Information

Provider Representative

* Required field

Prefix: Mr. Mrs. Ms. Dr.

First Name*:

Last Name*:

Street Address:

City:

State:

Zip Code:

Phone Number:

Daytime / Alternate:

Fax Number:

Email Address:

Provider Name & NPI# * :

Prefix: Mr. Mrs. Ms. Dr.

First Name*:

Last Name*:

Street Address:

City:

State:

Zip Code:

Phone Number:

Daytime / Alternate:

Fax Number:

Email Address:

TennCare Plan Information

My Request is against:	<input type="checkbox"/> Amerigroup RealSolutions (Amerigroup of TN HMO)
	<input type="checkbox"/> UnitedHealthcare Community Plan (UnitedHealthcare of the River Valley HMO)
	<input type="checkbox"/> BlueCare (Volunteer State Health Plan HMO)
	<input type="checkbox"/> TennCare Select (Volunteer State Health Plan HMO)
Type of Service:	<input type="checkbox"/> DentaQuest (DentaQuest USA, Dental Benefit Manager)
	<input type="checkbox"/> Magellan (Pharmacy Benefit Manager)
	<input type="checkbox"/> Physical Health <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental
	<input type="checkbox"/> Pharmacy <input type="checkbox"/> CHOICES <input type="checkbox"/> Transportation

Provider Type:

Provider Type examples: Hospital, Physician, Nursing Facility, Hospice, etc.

Date(s) of Service(s)

Start Date: _____ **End Date:** _____

Initial Claim Submission to MCC Date:

(Attach a copy of the Provider Claim.)

Initial MCC Claim Denial or Recoupment Date:

(Attach a copy of the MCC Denial or Recoupment Advice.)

Date Provider submitted written Reconsideration Request to MCC:

(Attach a copy of the Provider's Reconsideration Request.)

Date Provider received written Reconsideration Denial:

(Attach a copy of the MCC's Reconsideration Denial.)

Are you a contracted network provider? Yes No

(If Yes, attach evidence of contract. A copy of the signature page is sufficient.)

If you are not contracted with the MCC, you must submit the reviewer's fee with this request.

Have you enclosed the Fee? Yes No

Per claim, attach a check in the amount of \$750 made payable to the Department of Commerce and Insurance.

Reason(s) for Request

(Check all that apply)

Claim Denial = [CD]

<input type="checkbox"/> [CD] Untimely Filing	<input type="checkbox"/> [CD] Neither Paid nor Denied	<input type="checkbox"/> Claim Paid Incorrectly
<input type="checkbox"/> [CD] Service Not Covered	<input type="checkbox"/> [CD] Enrollee Not Eligible on DOS	<input type="checkbox"/> [CD] Hosp. In-Patient vs Observation
<input type="checkbox"/> [CD] Lack of Authorization	<input type="checkbox"/> [CD] Experimental/Investigational	<input type="checkbox"/> [CD] Other
<input type="checkbox"/> Claim Recoupment Error	<input type="checkbox"/> [CD] Medical Necessity - General	

Only claims which meet ALL of the requirements set forth in T.C.A. § 56-32-126(b)(2)(A) thru (D) are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible.

Please give a written description of the problem. (Limit to 5000 characters below. Attach additional pages if needed)

- Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim. Include all pertinent information.
- Attach copies of pertinent documentation, including any correspondence from the plan and remittance advices.

[Large greyed-out area for providing a written description of the problem]

Do you want your claims aggregated?

Yes No

Only claims involving a common question of fact or law may be aggregated. The fact that a claim is not paid does not create a common question of fact or law.

If you wish to aggregate your claims, explain the common question of fact or law:

ACKNOWLEDGEMENT OF FEE OBLIGATION

By my signature below, I hereby request independent review of the above claim, pursuant to T.C.A. §§ 56-32-126(b) or 71-5-2314. I also confirm that the above mentioned disputed claim will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer's fee. Any provider who initiates independent review for a non-TennCare claim is ultimately responsible for paying the reviewer's fee. I also understand that there is a mandatory fee of \$750.00 per claim and if I have a contract with the MCO, the MCO is initially responsible for paying the fee. I further understand that if the reviewer determines the MCO correctly denied payment of this disputed claim(s), then I must reimburse the MCO for the reviewer's fee as established by the Selection Panel for TennCare Reviewers.

If you are **NOT** the aggrieved provider, what is your relationship to the provider?

I declare that the information I've furnished is true and accurate.

Signature:

Date: