TennCare Oversight Division
500 James Robertson Parkway, 11th Floor
Nashville, TN 37243

Phone: (615) 741-2677
Fax: (615) 401-6834
TennCare.Oversight@TN.Gov

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*:

Provider Name:

Street Address:

City: State: Zip Code:

Phone Number: Daytime / Alternate:

Fax Number:

Email Address:

TennCare Plan Information

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

TennCare Plan Information (Continued)

Provider Type:	[Reserved]

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 $450 made payable to the Department of Commerce and Insurance.)

Reason(s) for Request (Check all that apply)

Claim Denial = [CD]

☐ [CD] Untimely Filing	☐ [CD] Neither Paid nor Denied	☐ Claim Paid Incorrectly
☐ [CD] Service Not Covered	☐ [CD] Enrollee Not Eligible on DOS	☐ [CD] Hosp. In-Patient vs Observation
☐ [CD] Lack of Authorization	☐ [CD] Experimental/Investigational	☐ [CD] Other
☐ Claim Recoupment Error	☐ [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.

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 $450.00 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: