

Phone: (615) 741-2677 Fax: (615) 401-6834 <u>TennCare.Oversight@TN.gov</u>

TennCare & CoverKids¹ Programs

Request to Commissioner for Independent Review of Disputed Provider Claim

Please complete and submit by email (preferred) <u>TennCare.Oversight@TN.gov</u>, fax, or mail. We will acknowledge receipt of your request by email. You will be copied on our correspondence concerning this matter by email. Please provide documentation that supports your dispute.

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

Requesting Provider 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 and National Provider Identi			
Prefix: Mr. Mrs. Ms. Dr.			
Name*:	NPI#*:		
Street Address:			
City:	State:	Zip Code:	
Phone Number:	Daytime / Alternate:		
Fax Number:	Email Address:		
¹ CoverKids disputes eligible effective 1/1/202	1		



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Health Plan Information

My Complaint is against Managed Care Company/Managed Care Organization ("MCC/MCO"):	 Wellpoint (fka Amerigroup) (Wellpoint Tennessee HMO) UnitedHealthcare Community Plan (UnitedHealth Care of the River Valley HMO) BlueCare (Volunteer State Health Plan HMO) TennCare Select (Volunteer State Health Plan HMO) DentaQuest (Dental Benefit Manager) OptumRx (Pharmacy Benefit Manager)
Type of Service:	Physical Health Behavioral Health Dental CHOICES Transportation
Line of Business/Program	TennCare CoverKids

Provider Type: _____

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

Enrollee Name:		DOB:	
If there are multiple enrollees, the names an		o be listed here. Include them in	the supporting
documentation/description of the problem.			
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 Dat	te:		
(Attach a copy of the MCC Denial or Recoup	ment Advice.)		
Date Provider submitted written Reconsider	ration Request to MC	C:	
(Attach a copy of the Provider's Reconsidera	ition Request.)		
Date Provider received written Reconsidera	tion Denial:		
(Attach a copy of the MCC's Reconsideration	ו Denial.)		
Are you a contracted network provider?	Yes	Νο	
(If yes <u>, attach evidence of contract</u> . A copy o	of the signature page	is sufficient.)	
If you are not contracted with the MCC, you	must submit the revi	iewer's fee with this request.	
Have you enclosed the Fee?	Yes	Νο	
Per claim, attach a check in the amount of \$	750 made payable to	the Department of Commerce	and Insurance.



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Reason(s) for Complaint

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	

Claims which meet <u>ALL</u> the requirements set forth in the Division of TennCare managed care contracts and T.C.A. § 56-32-126(b) (2) (A) thru (D) are eligible for Independent Review, including denied CoverKids program claims (CoverKids disputes eligible 1/1/2021). Claims payment disputes involved in litigation or arbitration are not eligible.

Please give a written description of the problem: (Attach additional pages if needed)

- Description may include, but not limited to, the 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?

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.

Yes

No



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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 Reviewer's.

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: _____ D

Date:
