



TennCare Oversight Division  
500 James Robertson Parkway  
Nashville, TN 37243

Phone: (615) 741-2677  
Fax: (615) 401-6834  
[TennCare.Oversight@TN.gov](mailto:TennCare.Oversight@TN.gov)

## TennCare & CoverKids<sup>1</sup> Programs

### Request to Commissioner for Independent Review of Disputed Provider Claim

Please complete and submit by email (preferred) [TennCare.Oversight@TN.gov](mailto:TennCare.Oversight@TN.gov), 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 Identifier (NPI)

Prefix:      Mr.    Mrs.    Ms.    Dr.

Name\*: \_\_\_\_\_ NPI#\*: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Daytime / Alternate: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

<sup>1</sup>CoverKids disputes eligible effective 1/1/2021





TennCare Oversight Division  
500 James Robertson Parkway  
Nashville, TN 37243

Phone: (615) 741-2677  
Fax: (615) 401-6834  
[TennCare.Oversight@TN.gov](mailto:TennCare.Oversight@TN.gov)

**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 ALL 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?       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.



TennCare Oversight Division  
500 James Robertson Parkway  
Nashville, TN 37243

Phone: (615) 741-2677  
Fax: (615) 401-6834  
[TennCare.Oversight@TN.gov](mailto:TennCare.Oversight@TN.gov)

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: \_\_\_\_\_ Date: \_\_\_\_\_