TN Department of Commerce & Insurance

TennCare Oversight Division
500 James Robertson Parkway, 8th Floor
Nashville, TN 37243

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

PROVIDER COMPLAINT FORM: Medicare Advantage Special Needs Plan ("MA-SNP")

Please complete this form, fax, email 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 and NPI#

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ LLC ☐ PC ☐ INC

Name*: _____ NPI#*: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Daytime / Alternate: _____

Fax Number: _____ Email Address: _____

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MA-SNP Plan Information

My Complaint is against Managed Care Company/Managed Care Organization **("MCC/MCO"):**	☐ **Amerivantage Specialty (Amerigroup of TN HMO SNP)** ☐ **BlueCare (VSHP Medicare Advantage HMO SNP)** ☐ **HealthSpring Total Care (HealthSpring of TN HMO SNP)** ☐ **Humana Medicare Advantage SNP (Humana Health Plan HMO SNP)** ☐ **UnitedHealthcare Dual Complete (UnitedHealthcare Plan of the River Valley HMO SNP)** ☐ **Windsor Medicare Extra Comp Plus (Windsor Health Plan HMO SNP)** ☐ **Windsor Medicare Extra Fusion Plan (Windsor Health Plan HMO SNP)**
Type of Service:	☐ **Physical Health** ☐ **Behavioral Health** ☐ **Dental** ☐ **Pharmacy** ☐ **Transportation**

Provider Type: _____

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

Enrollee Name: _____ DOB: _____

If there are multiple enrollees, the names and DOBs do not need to be listed here. Include them in the supporting documentation/description of the problem.

Date(s) of Service(s):

Start Date: _____ End Date: _____

Reason(s) for Complaint

Claim Denial = [CD]

☐ [CD] Untimely Filing ☐ [CD] Enrollee Not Eligible on DOS ☐ [CD] Service Not Covered

☐ [CD] Lack of Authorization ☐ [CD] Experimental/Investigational ☐ [CD] Other

☐ Claim Payment Delay ☐ Claim Paid Incorrectly ☐ Duplicate

☐ Recoupment Error ☐ Medical Necessity – General ☐ Other MCC operational problems

☐ Non-renewal of Provider Agreement and/or Network status

☐ Medical Necessity – Hospital Inpatient vs Hospital Observation

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

- **Include all pertinent information**
- **Attach copies of pertinent documentation, including any correspondence from the plan and remittance advices.**

If you are complaining about claim denials/recoupments for services rendered to 5 or more health plan members, please mail/deliver to us an electronic Excel Spreadsheet on an encrypted CD that includes the following information:

• **Member Name (First, Middle, Last)**	• **Service Type**
• **Member Birth Date (DOB)**	• **Service Location/Facility Name**
• **From Service Date (FDOS)**	• **Remit Date (Denied or Paid)**
• **To Service Date (TDOS)**	• **Issue &/or other information that would assist in resolving this complaint**
• **Do NOT include multiple MCCs in one spreadsheet**	

Tell us what you want the TennCare MCC or the TennCare Bureau to do to resolve your complaint.

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:_____