TennCare Oversight Division
500 James Robertson Parkway
Nashville, TN 37243

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

PROVIDER COMPLAINT: TennCare and CoverKids Programs

Please complete and submit by email (preferred), fax, or mail. We will acknowledge receipt of your Complaint by email. You will be copied on our correspondence concerning this matter by email. 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.

Name*: _______________________________________ NPI#*: ____

Street Address: ____

City: ______________________________________ State: __________ Zip Code: ___________________

Phone Number: _________________________ Daytime / Alternate: ______________________________

Fax Number: __________________________ Email Address: ____

Department of Commerce & Insurance

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TennCare Plan Information

My Complaint is against:	☐ **Amerigroup (Amerigroup of TN 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)** ☐ **Optum Rx (Pharmacy Benefit Manager)** ☐ **Division of TennCare (Bureau) (Medicare Cross-Over Claims) TennCare** ☐ **Division of TennCare (Bureau) (Medicaid Reclamation Claims)**
Type of Service:	☐ **Physical Health** ☐ **Behavioral Health** ☐ **Dental** ☐ **Pharmacy** ☐ **CHOICES** ☐ **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 ☐ Credentialing problems

☐ Non-renewal of Provider Agreement and/or Network Status ☐ Other MCC operational problems

☐ 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.**

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If you are complaining about claim denials/recoupments for services rendered to 5 or more health plan members, please submit an Excel Spreadsheet 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 TDFA Division of TennCare (Bureau) to do to resolve your complaint.

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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: _______________________