

## PROVIDER COMPLAINT FORM: Medicare Advantage Special Needs Plan (“MA-SNP”)

Please complete this form 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\*:

Street Address:

City:

State:

Zip Code:

Phone Number:

Daytime / Alternate:

Fax Number:

Email Address:

### Provider Name & 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:

**MA-SNP Plan Information**

My Complaint is against:	<input type="checkbox"/> Amerivantage Specialty (Amerigroup of TN HMO SNP) <input type="checkbox"/> BlueCare Plus (VSHP Medicare Advantage HMO SNP) <input type="checkbox"/> HealthSpring TotalCare (HealthSpring of TN HMO SNP) <input type="checkbox"/> Humana Medicare Advantage SNP (Humana Health Plan HMO SNP) <input type="checkbox"/> UnitedHealthcare Dual Complete (UnitedHealthcare Plan of the River Valley HMO SNP) <input type="checkbox"/> Windsor Medicare Extra Comp Plus (Windsor Health Plan HMO SNP) <input type="checkbox"/> Windsor Medicare Extra Fusion Plan (Windsor Health Plan HMO SNP)
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Type of Service:	<input type="checkbox"/> Physical Health <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental  <input type="checkbox"/> Pharmacy <input type="checkbox"/> Transportation
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**Provider Type:**

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

**Date(s) of Service(s):**

Start Date:

End Date:

**Reason(s) for Complaint**

Claim Denial = [CD]

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> [CD] Untimely Filing   | <input type="checkbox"/> [CD] Enrollee Note Eligible on DOS | <input type="checkbox"/> [CD] Service Not Covered       |
| <input type="checkbox"/> [CD] Lack of Authorization                                     | <input type="checkbox"/> [CD] Experimental/Investigational  | <input type="checkbox"/> [CD] Other                     |
| <input type="checkbox"/> Claim Payment Delay  | <input type="checkbox"/> Claim Paid incorrectly             | <input type="checkbox"/> Duplicate                      |
| <input type="checkbox"/> Recoupment Error   | <input type="checkbox"/> Medical Necessity – General        | <input type="checkbox"/> Other MCC operational problems |
| <input type="checkbox"/> Non-renewal of Provider Agreement and/or Network status        |   |   |
| <input type="checkbox"/> Medical Necessity – Hospital Inpatient vs Hospital Observation |   |   |

TennCare Oversight Division  
500 James Robertson Parkway, 11<sup>th</sup> Floor  
Nashville, TN 37243

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

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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 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.

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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: \_\_\_\_\_