

**REQUEST to COMMISSIONER of COMMERCE & INSURANCE for  
INDEPENDENT REVIEW of DISPUTED TENNCARE CLAIM**

**TO:** Compliance Officer, TennCare Division, Tenn. Dept. of Commerce & Insurance  
500 James Robertson Parkway, 11<sup>th</sup> Floor, Nashville, TN 37243-1169  
Telephone: (615) 741-2677 or Fax: (615) 532-8872

**FROM:** Provider Contact Person: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_  
Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Fill out this form completely or it may be returned as ineligible. Read the attached Instruction Sheet for completing this form.**  
(Submit a separate request form for each claim unless claims will be aggregated. See # 14 below.)

1. Provider Name: \_\_\_\_\_
2. TennCare MCO that denied claim: \_\_\_\_\_
3. Date(s) of Service(s): \_\_\_\_\_
4. Enrollee Name & ID #: \_\_\_\_\_
5. Claim(s) Amount: \_\_\_\_\_
6. Initial claim(s) submission date: \_\_\_\_\_
7. **Attach submitted claim(s).**
8. Date MCO partially or totally denied payment of claim (s): \_\_\_\_\_
9. **Attach MCO written denial(s). [Claim(s) must be submitted to Independent Review within 365 days of the MCO's 1<sup>st</sup> denial.]**
10. Date Provider requested reconsideration in writing: \_\_\_\_\_. **(Reconsideration request is required, regardless of whether a denial was received.)**
11. **Attach copy of dated written reconsideration request.**
12. **Attach MCO's response to your reconsideration request if you received one.**
13. **Briefly** describe disputed claim. Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. 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. If you wish to aggregate your claims, explain the common question of fact or law: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Only claims which meet ALL of the requirements set forth in T.C.A. § 56-32-126(b)(2)(A) thru (D) are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible.**

**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 \$450.00 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 Reviewers.

15. Are you a contracted provider with the MCO? \_\_\_ Yes \_\_\_ No
16. **Attach evidence of contract.** (A copy of the signature page from the provider contract is sufficient.)
17. **If you do not have a contract with the MCO, you must submit the reviewer's fee with your request.** (Per claim, attach check for \$450 made payable to the Department of Commerce and Insurance).
18. Amount of check sent to TN Dept. of Commerce and Insurance for the reviewer's fee: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature (Name & Title)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Type or Print Name & Title)