TN Department of Commerce & Insurance

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 Program Episode of Care Cycle Provider Gain/Risk Share Total Complaint

Please complete and submit by email (preferred) TennCare.Oversight@TN.gov, 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 member's name and other demographic information.

**Complaintant 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: __________________________________________

TN Department of Commerce & Insurance

TennCare Oversight Division
500 James Robertson Parkway
Nashville, TN 37243

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

**TennCare Plan Information**

| **My Complaint is against Managed Care Company/Managed Care Organization ("MCC/MCO"):** | ☐ **Amerigroup (Amerigroup Tennessee HMO)**<br>☐ **United Healthcare Community Plan (UnitedHealthcare of the River Valley HMO)**<br>☐ **BlueCare (Volunteer State Health Plan HMO)**<br>☐ **TennCare Select (Volunteer State Health Plan HMO)** |
|---|---|

| **Type of Episode:**<br>as identified in the Report | Select One |
|---|---|

**Provider Type:** ________________________________

*Provider Type examples: Hospital, Physician, or Physician Group*

**Date(s) of EoC Cycle Performance Report Period:**

**Start Date:** _________________________ **End Date:** _______________________

**Episode of Care Performance Report Date:**
*(Attach a copy of the Final Episode of Care Provider Performance Report)*
**Reason(s) for the Provider Complaint:**

☐ Average Cost calculated incorrectly

☐ All valid episode service claims not included

☐ Included claims that were not valid episode service claims

☐ Risk Sharing Factor was calculated incorrectly

☐ Report did not include the total number of cycle valid episodes (included and excluded)

☐ Quality Metrics Acceptable Thresholds not used correctly

☐ Metrics Commendable Threshold not used correctly

☐ Other

TN Department of Commerce & Insurance

TennCare Oversight Division
500 James Robertson Parkway
Nashville, TN 37243

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

**Amount in Dispute because the MCC did not calculate the Correct Total Gain/Risk Share:**

- ☐ Amount owed by Provider to MCC is not correct and should equal the amount of: ______________________
- ☐ Amount owed by Provider to MCC is not correct and should equal zero
- ☐ Amount owed by Provider to MCC is not correct and the MCC should owe Provider the amount of: _________________
- ☐ Determination by MCC that there is not a gain or that the risk share amount is not correct and the MCC should owe Provider the amount of: __________
- ☐ Amount owed by MCC to Provider is not correct and should equal the amount of: _____________________

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

- **Description should include an explanation why the value of the MCO's Total Gain/Risk Share is not correct. Please include all pertinent information in your position description.**
- **Attach copies of pertinent documentation, which may include correspondence with the MCC, Episode of Care Quarterly Review Reports, or remittance advices (as applicable) concerning the problem with this Episode of Care.**

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Tell us what you want the TennCare MCC or the TDFA Division of 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:** _____________________________