



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) 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 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 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: _____



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TennCare Plan Information

My Complaint is against:	<input type="checkbox"/> Amerigroup (Amerigroup Tennessee HMO) <input type="checkbox"/> UnitedHealthcare Community Plan (UnitedHealth Care of the River Valley HMO) <input type="checkbox"/> BlueCare (Volunteer State Health Plan HMO) <input type="checkbox"/> TennCare Select (Volunteer State Health Plan HMO) <input type="checkbox"/> DentaQuest (Dental Benefit Manager) <input type="checkbox"/> OptumRx (Pharmacy Benefit Manager) <input type="checkbox"/> Division of TennCare (Bureau) (Medicare Cross-Over Claims) TennCare <input type="checkbox"/> Division of TennCare (Bureau) (Medicaid Reclamation Claims)
Type of Service:	<input type="checkbox"/> Physical Health <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> CHOICES <input type="checkbox"/> 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]

- | | | |
|---|--|---|
| <input type="checkbox"/> [CD] Untimely Filing | <input type="checkbox"/> [CD] Enrollee Not 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"/> Credentialing problems |
| <input type="checkbox"/> Non-renewal of Provider Agreement and/or Network Status | | <input type="checkbox"/> Other MCC operational problems |
| <input type="checkbox"/> 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/recoups 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.

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: _____

