



TennCare Oversight Division
500 James Robertson Parkway
Nashville, TN 37243

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

TennCare & CoverKids¹ Programs

Request to Commissioner for Independent Review of Disputed Provider Claim

Please complete and submit by email (preferred) TennCare.Oversight@TN.gov, fax or mail. We will acknowledge receipt of your Request by email. You will be copied on our correspondence concerning this matter by email. Please provide documentation that supports your dispute.

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.

Requesting Provider 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: _____

¹CoverKids disputes eligible effective 1/1/2021



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Health Plan Information

My Complaint is against Managed Care Company/Managed Care Organization ("MCC/MCO"):	<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)
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
Line of Business/Program	<input type="checkbox"/> TennCare <input type="checkbox"/> CoverKids

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: _____

Initial Claim Submission to MCC Date: _____

(Attach a copy of the Provider Claim.)

Initial MCC Claim Denial or Recoupment Date: _____

(Attach a copy of the MCC Denial or Recoupment Advice.)

Date Provider submitted written Reconsideration Request to MCC: _____

(Attach a copy of the Provider's Reconsideration Request)

Date Provider received written Reconsideration Denial: _____

(Attach a copy of the MCC's Reconsideration Denial)

Are you a contracted network provider? Yes No

(If Yes, attach evidence of contract. A copy of the signature page is sufficient.)

If you are not contracted with the MCC, you must submit the reviewer's fee with this request.

Have you enclosed the Fee? Yes No



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Per claim, attach a check in the amount of \$750 made payable to the Department of Commerce and Insurance.

Reason(s) for Complaint

Claim Denial = [CD]

- | | | |
|---|--|--|
| <input type="checkbox"/> [CD] Untimely Filing | <input type="checkbox"/> [CD] Neither Paid nor Denied | <input type="checkbox"/> Claim Paid Incorrectly |
| <input type="checkbox"/> [CD] Service Not Covered | <input type="checkbox"/> [CD] Enrollee Not Eligible on DOS | <input type="checkbox"/> [CD] Hosp In-Patient vs Observation |
| <input type="checkbox"/> [CD] Lack of Authorization | <input type="checkbox"/> [CD] Experimental/Investigational | <input type="checkbox"/> [CD] Other |
| <input type="checkbox"/> Claim Recoupment Error | <input type="checkbox"/> [CD] Medical Necessity – General | |

Claims which meet ALL the requirements set forth in the Division of TennCare managed care contracts and T.C.A. § 56-32-126(b) (2) (A) thru (D) are eligible for Independent Review, including denied CoverKids program claims (CoverKids disputes eligible 1/1/2021). Claims payment disputes involved in litigation or arbitration are not eligible.

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

- Description may include, but not limited to, the reason given for denial and your position explaining why the MCO should pay the claim. Include all pertinent information.
- Attach copies of pertinent documentation, including any correspondence from the plan and remittance advices.

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.





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If you wish to aggregate your claims, explain the common question of fact or law:

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 \$750.00 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 Reviewer’s.

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: _____

