



TennCare Oversight Division  
 500 James Robertson Parkway  
 Nashville, TN 37243

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

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

Please complete and submit by email (preferred) [TennCare.Oversight@TN.gov](mailto: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.

### Complainant Information

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#### Provider Representative

\* Required field

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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: \_\_\_\_\_

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**MA-SNP Plan Information**

My Complaint is against Managed Care Company/Managed Care Organization ("MCC/MCO"):	<input type="checkbox"/> Amerivantage Specialty (Amerigroup Tennessee HMO SNP) <input type="checkbox"/> BlueCare (VSHP Medicare Advantage HMO SNP) <input type="checkbox"/> HealthSpring Total Care (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)
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

**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]**

- [CD] Untimely Filing       [CD] Enrollee Not Eligible on DOS       [CD] Service Not Covered
- [CD] Lack of Authorization     [CD] Experimental/Investigational       [CD] Other
- Claim Payment Delay       Claim Paid Incorrectly       Duplicate
- Recoupment Error       Medical Necessity – General       Other MCC operational problems
- Non-renewal of Provider Agreement and/or Network status
- 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

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If you are complaining about claim denials/recoupments 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.

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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: \_\_\_\_\_

