TennCare Oversight Division
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PROVIDER COMPLAINT FORM: Medicare Advantage Special Needs Plan ("MA-SNP")

Please complete this form and fax or mail it back to us. You will be copied on our correspondence concerning this matter. 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*:	
Provider Name:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Email Address:		

MA-SNP Plan Information

My Complaint is against:	☐ Amerivantage Specialty (Amerigroup of TN HMO SNP) ☐ BlueCare Plus (VSHP Medicare Advantage HMO SNP) ☐ HealthSpring TotalCare (HealthSpring of TN HMO SNP) ☐ Humana Medicare Advantage SNP (Humana Health Plan HMO SNP) ☐ UnitedHealthcare Dual Complete (UnitedHealthcare Plan of the River Valley HMO SNP) ☐ Windsor Medicare Extra Comp Plus (Windsor Health Plan HMO SNP) ☐ Windsor Medicare Extra Fusion Plan (Windsor Health Plan HMO SNP)
Type of Service:	☐ Physical Health ☐ Behavioral Health ☐ Dental ☐ Pharmacy ☐ Transportation

MA-SNP Plan Information (Continued)

Provider Type:	[Reserved]

Provider Type examples: *Hospital, Physician, Nursing Facility, Hospice, etc.*

Date(s) of Service(s)

Start Date: End Date:

[Reserved] ☐ ☐

Reason(s) for Complaint (Check all that apply)

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	
☐ 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		

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/recoupments for services rendered to 5 or more health plan members, please mail/deliver to us an electronic Excel Spreadsheet on a CD that includes the following information:

- Member Name (First, Middle, Last)
- Member Birth Date (DOB)
- From Service Date (FDOS)
- To Service Date (TDOS)
- Service Type
- Service Location/Facility Name
- Remit Date (Denied or Paid)
- 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 MA-SNP plan 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: