TennCare Oversight Division
500 James Robertson Parkway, 11th Floor
Nashville, TN 37243

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

PROVIDER COMPLAINT FORM: TennCare Program

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:		

TennCare Plan Information

My Complaint is against:	☐ Amerigroup RealSolutions (Amerigroup of TN HMO) ☐ UnitedHealthcare Community Plan (UnitedHealth Care of the River Valley HMO) ☐ BlueCare (Volunteer State Health Plan HMO) ☐ TennCare Select (Volunteer State Health Plan HMO) ☐ DentaQuest (Dental Benefit Manager) ☐ Magellan (Pharmacy Benefit Manager) ☐ TennCare Bureau (Medicare Cross-Over Claims) ☐ TennCare Bureau (Medicaid Reclamation Claims)
Type of Service:	☐ Physical Health ☐ Behavioral Health ☐ Dental ☐ Pharmacy ☐ CHOICES ☐ Transportation

TennCare 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 TennCare MCC or the 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: