carolina complete health

PROVIDER CLAIM COMPLAINT/APPEAL FORM

Use this form as part of the Carolina Complete Health's Complaint/Appeal process to address the decision made during the request for review process. This form should be utilized if a claim has been processed and a Medicaid Remittance Advice has been issued from Carolina Complete Health. **Do not use for first time claims or corrected claims.** For corrected claims, please use the claims resubmission process outlined in the provider manual.

A Claim Complaint is a written expression by a Provider which indicates dissatisfaction or dispute with Carolina Complete Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service. All claim requests for complaint must be received within thirty (30) calendar days from the date of the Medicaid Remittance.

A Claim Appeal is the mechanism following the exhaustion of the complaint process that allows providers the right to appeal actions of Carolina Complete Health. Carolina Complete Health will accept a written request for an appeal from the provider within thirty (30) calendar days if the Provider receives written notice from Carolina Complete Health of the decision giving rise to the right to appeal; or if Carolina Complete Health should have taken a required action and failed to take such actions.

All fields below are required information. Failure to complete the form may result in a delay of your request. Please check the appropriate box below.

Member's Name:	Member's Medicaid Number:
Date(s) of Service:	Control/Claim Number(s):
Medicaid Remittance Date:	Billed Charge(s):
Provider Name:	Provider TIN Number:
Medicaid Provider Number:	Provider Contact Number:
Contact Name:	Contact Address:

☐ COMPLAINT: Originally submitted claim and Medical Remittance.

☐ APPEAL: Must include Carolina Complete Health written notice of right to appeal and may include medical records or other medical information.

Please include relevant claim information and any supporting medical or clinical documentation with this form and mail to the following address:

Carolina Complete Health
P.O. Box 8040
Farmington, MO 63640-8040

Please refer to the Carolina Complete Health Provider Manual and the Carolina Complete Health Billing manual for specific turnaround time for complaint and appeal resolution. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision) or overturn our original decision (if we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance.)

This form may be photocopied