Claim Reconsideration and Grievance Form
Instructions

Use this form to submit a **Claim Reconsideration (Level I)** or **Claim Grievance (Level II)** through the **Secure Provider Portal** or by mail. For information related to claim corrections, review the **CCH Billing Manual**.

- **Claim Reconsideration (Level I):** To dispute original claim determination, submit a reconsideration request. Contracted Providers must submit claim reconsiderations within 365 calendar days from the date of the EOP or ERA. Non-Contracted Providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA.
- **Claims Grievance (Level II):** To express dissatisfaction regarding the amount reimbursed or the denial of a particular service following the exhaustion of the claim reconsideration process. Carolina Complete Health will accept a request for a claim grievance from the provider within thirty (30) calendar days of the EOP or ERA.

How do I submit a Claims Reconsideration or Claims Griveance?

Claim Reconsiderations and Grievances can be submitted two ways:

1. Via the **Secure Provider Portal** (Preferred Method, see page 3)
2. Completion and mailing or faxing of this form (page 2) and associated attachments, including a copy of the EOP(s) with claim(s) clearly circled to:

Claim Reconsiderations (Level I)
Medicaid Claims Reconsiderations/Disputes Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

Claim Grievance (Level II)
Claim Grievances
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

Fax: 833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.

Note: Claim Reconsiderations and Claim Grievances submitted directly to the health plan's mailing address will not be processed.

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Claim Reconsideration and Grievance Form

Use this form to submit a **Claim Reconsideration (Level I)** or **Claim Grievance (Level II)** through the mail. For information related to claim corrections, review the **CCH Billing Manual**.

Select Claim Reconsideration or Claim Grievance and then complete the required fields. Please submit form with all associated attachments, including a copy of the EOP(s) with claim(s) clearly circled.

☐ **Claim Reconsideration (Level I)** ☐ **Claim Grievance (Level II)**

Please Note: Carolina Complete Health will make reasonable efforts to resolve this request within 30 (thirty) days of receipt.

Date of Request:	

Provider/Group Name	**Provider Tax ID Number**	**Provider NPI Number**
Provider Company	**Date of Service**	**Date of Last EOP**
Member Name	**Member ID Number**	**Claim Number*** **Enter Multiple Claim Numbers*
Name of Person Completing Form *(Requestor)*	**Requestor Phone Number**	**Requestor Email Address**

Reason for Request (Please select applicable)

- ☐ Claim was denied for no authorization, but authorization number was obtained.
- ☐ Claim was submitted with incomplete or invalid information.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for untimely filing in error (proof of timely filing should be attached).
- ☐ Claim was paid to wrong provider.
- ☐ Claim was paid for incorrect amount.
- ☐ Other (please explain below):

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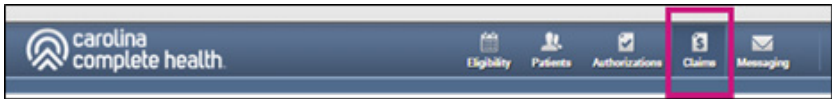
Submitting a Claim Correction, Reconsideration, or Grievance via the Secure Provider Portal Instructions

Providers seeking to file grievances or appeals related to health plan operations (such as dissatisfaction with health plan policies or operations) or related to fraud, waste or abuse allegation or withhold/ suspension, must follow the guidance outlined within the **Provider Manual**.

Step by Step Guide

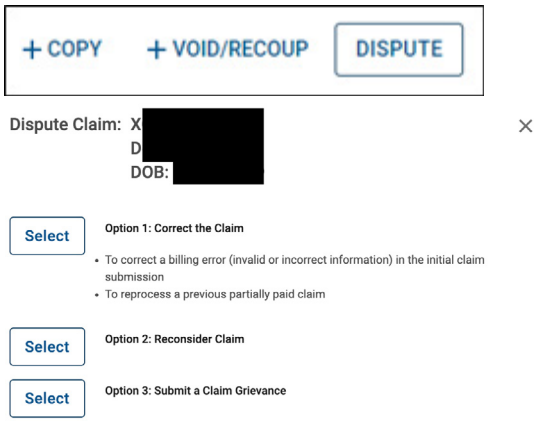
Step 1. Login to the Secure Provider Portal at provider.carolinacompletehealth.com.

Step 2. Click on "Claims" in the toolbar.



Step 3. Search for the claim by entering the claim number and click "CHECK".

Step 4. In the claim details view, Click "DISPUTE" button, then select the appropriate option. Option 1: "Correct the Claim" or Option 2: "Reconsider Claim" or Option 3: "Submit a Claim Grievance." Providers must exhaust Option 2 prior proceeding to Option 3. **Note: The provider portal attachment size limit is 25 MB. You can include more than one attachment, but the total cannot exceed 25 MB.**



Questions/Concerns

If you have questions/concerns regarding this process, please contact your Provider Network Support Specialist at NetworkRelations@cch-network.com or by phone at 1-833-522-3876.

Last Revised: November 4, 2024