COVER SHEET INSTRUCTION

Claim Disputes and Appeals

Purpose and Usage of the Provider Cover Sheet

- The provider cover sheet should **only** be used by Providers to request a formal review of **Claim related denials**. **A dispute or appeal can be submitted using this form. See the definitions below.**
- For Medicaid plans this cover sheet can **accompany other submission materials and health place specific forms for claim related denials items only.**
- Providers are responsible for ensuring all submitted information is accurate and complete. Incomplete submissions may result in delays or denials.
- This form is not intended for bulk submissions.

Definitions

- **Claim Appeal:** A review requested by a provider in response to an initial adverse authorization determination made by the health plan.
- **Claim Dispute:** A request by a provider to dispute an adverse initial determination made by the health plan regarding payment of a claim.

When submitting this form fill out the following information to complete the request:

- **Provider Information:** Name, Tax ID, and NPI.
- **Member Information:** Name, Member ID, Date(s) of Service.
- **Claim Information:** Claim number, Date of last Explanation of Payment (EOP).
- **Reason for Request:** Explanation of reason for request, including applicable authorization numbers if applicable.
- **Provider's contact name and number** for any questions or further information.

(continued)

Required documentation for each submission in addition to the completed cover sheet:

- **Claim Appeal:**
  - Appeal letter detailing the reason for the appeal (for appeals based on medical necessity).
  - Medical records pertinent to the claim denial.
  - Authorization proof if the claim was denied for no authorization.
- **Claim Dispute:**
  - Itemized bills or invoices for payment disputes.
  - Explanation of Benefits (EOB) from primary insurance for coordination of benefits issues.
- **All Submissions:**
  - Any additional documentation that supports the request, such as correspondence, additionalmedical records, or proof of timely filing.
- **Any incomplete submissions will not be processed and will be sent back for completion.**

Time Frames and Deadlines

- **Provider Claim Disputes** must be submitted within ninety (90) calendar days from the date of the EOP/ERA (par providers) and sixty (60) days from the date of the EOP/ERA for non-par providers.
- **Provider Claim Appeals** must be submitted within sixty (60) days of the original authorization notice date. After sixty (60) calendar days, the original authorization determination becomes final.

Additional Notes:

- If the request involves multiple claims denied for the same reason, please reach out to your ProviderRelations Representative for support on bulk submission.
- We recommend all providers to use the Provider Web Portal for submissions. If submitting requestvia portal submission, do not use this form. Please refer to your Provider Manual for Portal process.

carolina complete health

COVER SHEET INSTRUCTION

Claim Disputes and Appeals

This coversheet is to be used when you have a claim related appeal or payment dispute. It may be used by Providers for Medicaid plans.

Fill out the form completely with clear identification of request and keep a copy for your records. Please submit one cover sheet for each claim request to help ensure timely and accurate processing. Your request will be processed once all necessary documentation is received. See below check-list containing necessary documentation to attach for your appeal or dispute. A resolution letter will be sent to the address on file.

This form should be used when submitting your appeal/or dispute and **mailed to the following address:**

Carolina Complete Health
Attn: Medicaid Claim Disputes/Appeals Department
PO Box 8040
Farmington, MO 63640-8040

You may also fax the Appeal request to 1-833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.

Plan identification details:

Member ID: _____

☐ Medicaid

Please select what you are requesting:

☐ Claim Appeal

☐ Claim Payment Dispute

Submission details: ☐ Par Provider ☐ Non-Par Provider

Provider/Facility name: _____

Provider Tax ID: _____

NPI: _____

Claim #: _____

Dates of Service: _____

Authorization # (if applicable): _____

Number of pages in request: _____

Please include the items below that are relevant for your submission. Check each box indicating what is attached to the request:

☐ Medical records ☐ Itemized Bills ☐ WOL (Waiver of Liability, Medicare Non-Par Providers ONLY)

☐ AOR (Appointment of Representative, Medicare Non-Par Provider 3rd Party Appellants ONLY)

☐ Additional Information Provided (check box and list document type):

Reason for the request: _____

_____

Contact Person for Request: _____

Direct Phone Number for Contact Person: _____

Contact Person – Fax #: _____

Signature: _____ Date: _____