FORM: Provider Hardship and Stabilization Form

Prior to submitting the form, please ensure that the information below aligns with NCTracks to prevent delays. Please submit the completed form to networkrelations@cch-network.com.

☐ Stabilization ☐ Hardship

Date of Request: _____

Provider/Business Name: _____

County: _____

Provider NPI (who will receive the advance): _____

Name and Title of staff person submitting hardship request:

_____

Email of staff person submitting hardship request: _____

Phone number of staff person submitting hardship request: _____

Please complete the below for a Hardship request ONLY.

Briefly explain the reason for this request, list the financial obligations unable to be met:

Estimate total monetary impact to you (provider) of unpaid managed care claims:

_____

Provide a list of unpaid Carolina Complete Health claims and the reason the claim has not been paid:

Continued on page 2.

Reason for claim denial:

For Carolina Complete Health Use Only:

Date Received: _____

Analysis Completed By: _____

Decision: _____

Amount Approved: _____