carolina complete health

Claims and Billing Guide

Claim Corrections, Reconsiderations, and Grievances

Quick Reference Table

Action	Definition	Timely Filing	Method	Additional Notes
Correction	For claims that include a correction to the initial claim submission. For example, to correct a invalid or incorrect information in the initial submission.	Contracted Providers: submitters have 365 calendar days from the date of service to file a timely corrected claim. Non-Contracted Providers: submitters have 180 calendar days from the date of service to file a timely corrected claim.	EDI, provider secure web portal or to the address below: Medicaid Claims Department Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	
Reconsideration	To dispute original claim determination, complete and submit dispute to request additional review.	Contracted Providers: Providers must submit claim reconsiderations within 365 calendar days from the date of the EOP or ERA. Non-Contracted Providers: Providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA.	Secure provider or to the address below: Medicaid Claims Reconsiderations/Disputes Department Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	Claim reconsideration do not include decisions related to retro authorization and adverse medical necessity determination. If submitting a claim reconsideration through the mail, use the Claim Reconsideration and Grievance form: network.carolinacompletehealth.com/forms

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Action	Definition	Timely Filing	Method	Additional Notes
Grievance	To express dissatisfaction regarding the amount reimbursed or the denial of a particular service following the exhaustion of the claim reconsideration process.	Providers must submit claim grievances within 30 calendar days from the date of the EOP or ERA.	Secure provider or to the address below: Claim Grievances Carolina Complete Health P.O. Box 8040 Farmington, MO 63640-8040	Claim grievances do not include decisions related to prior authorization and adverse medical necessity determinations. For those concerns, Provider must follow the applicable retrospective review or beneficiary appeal process. If submitting a claim reconsideration through the mail, use the Claim Reconsideration and Grievance form: network.carolinacompletehealth.com/forms

Where can I find more details?

- For more information, please see the NCDHHS Provider Playbook Prompt Payment Fact Sheet (PDF) and the CCH Billing Manual.

Support

Please view the Provider section of our website at **network.carolinacompletehealth.com** for additional tools and resources. You may also contact the Provider Network Support Specialist Team directly via Email at NetworkRelations@cch-network.com, or contact Provider Services for assistance at **1-833-552-3876 (TTY 711)**.