



# Florida Statewide Medicaid Managed Care Program Complaint Form

If you have a complaint about Medicaid Managed Care services, please complete the information below.

If you need assistance completing this form or wish to verbally report your issue, please call 1-877-254-1055 to speak to a Medicaid representative.

\* Required fields

## Complainant Information

Your name

Your email

Your phone number

**2** I am a  \*

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1. Enter the name, email, and phone number of the best person to be reached regarding the complaint.
2. Complete all fields with an \*.
  - Select **“I am a healthcare provider”**
  - After selecting the type of complainant, additional fields will appear.

Provider Business Name:

Provider NPI:

Provider Staff contact name (if different from above):

Provider Staff contact phone number (if different from above):

**5** Type of Business  \*

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3. Enter the individual or group provider name and NPI.
4. Enter the provider contact that is the most knowledgeable about the complaint, if different from question 1.
5. Select the business type.

## Who is the complaint/issue about?

Recipient Name (If different from above)

Recipient Gold Card, SSN, or Medicaid number

(If the issue pertains to more than one recipient, please include Gold Card, SSN, or Medicaid ID for each person in the Comment below, or upload in the Attachment section)

County  \*

Have you previously submitted this issue, or a similar one, to the Agency?  Yes  No \*

What type of Managed Care Plan is this complaint/issue about?  \*

What is the name of the Managed Care Plan?  \*

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6. Recipient details are not required to submit a form.
  - If needed, one example can be entered, or an attached list can be uploaded.
7. Complete all fields with an \*.
  - A single issue across multiple plans requires a form for each plan.
  - Multiple issues related to a single plan require only one form.
  - HOWEVER
  - Multiple issues on a single form may impede ability of AHCA to identify discrete trends associated with specific health plans.

“Other/None” may be selected for name of Managed Care Plan but this does not permit AHCA to conduct plan-specific trending or AHCA to inquiry and follow-up with health plan.

**Please complete all choices that relate to your issue:**

I am a recipient and am having trouble obtaining the following service:

I am a new member and I have not received any plan information. If yes, check here:

I am having trouble finding a healthcare provider. If yes, check here:

I have questions about or need help with the plan complaint, grievance, appeal and/or Fair Hearing process. If yes, check here:

I have a complaint about my facility or its staff (Nursing Facility, Assisted Living Facility, Adult Family Care Home, Hospice). If yes, check here:

I am trying to enroll in a plan, disenroll from my plan or change my plan and need help. If yes, check here:

I am a Healthcare provider, and my complaint is about obtaining authorizations or claims payment issues. If yes, check here:

Payment Issue Type:

8. Choose the check box to indicate a Healthcare provider complaint.
  9. Choose the payment issue type from the drop down menu.
    - Difficulties or experiencing delays in obtaining authorization
- OR**
- Billed the plan and claims have denied or paid incorrectly

**AUTHORIZATION COMPLAINT**

I am a Healthcare provider, and my complaint is about obtaining authorizations or claims payment issues. If yes, check here:

Payment Issue Type:

When did you first submit your Authorization Request to the Plan?:  **1**

What procedure code was listed on the Request?:

Was service provided to the patient?  Yes  No \*

If you contacted the Plan about the problem, please describe their response in the Comment box below.

Please describe in 2000 characters or less:  **2**

Do you want to be contacted about this complaint/issue?  Yes  No \*

Attach Supporting File:

1. Complete all fields with an \*
- Enter the earliest date of authorization request if there are multiple requests.
- Enter at least one service code (i.e. CPT, revenue, etc.), that is related to the complaint if multiple codes.
- Indicate if service was provided to patient.
2. Describe the issue related to the complaint. List the different issues separately if there are multiple issues (i.e. delays, reversals, coverage, etc.).

Indicate if follow-up contact is desired\*

Supporting documentation is not required to submit a form BUT can be helpful in clarifying issues.

**PAYMENT COMPLAINT**

I am a Healthcare provider, and my complaint is about obtaining authorizations or claims payment issues. If yes, check here:

Payment Issue Type:

Have you contacted the Plan about this issue?  Yes  No \*

When did you first submit these claims?:  **1**

Are you billing electronically?  Yes  No \*

What are the date(s) of service?:

What are the CPT code(s) you are billing for?:

What are the total amount(s) of your outstanding claim(s)?

Please describe in 2000 characters or less:  **2**

Do you want to be contacted about this complaint/issue?  Yes  No \*

Attach Supporting File:

1. Complete all fields with an \*
- Enter the earliest claim submission date for the claim complaint if there are multiple claims.
- Enter the earliest date of service if there are multiple claim dates of service.
- Enter at least one service code that is related to the claim complaint if there are multiple codes.
- Enter the total amounts of outstanding claims for at least one issue if there are multiple claim issues.
2. Describe the issue related to the complaint. List the different issues separately if there are multiple claim issues (i.e. recoupment, denial, overpayment, etc.).