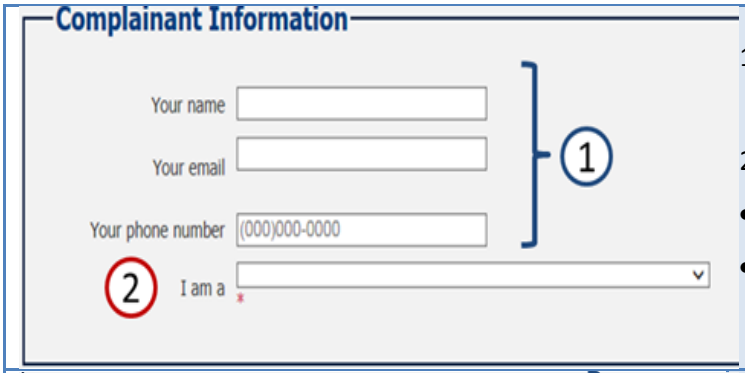
Florida Statewide Medicaid Managed Care Program Complaint Form

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

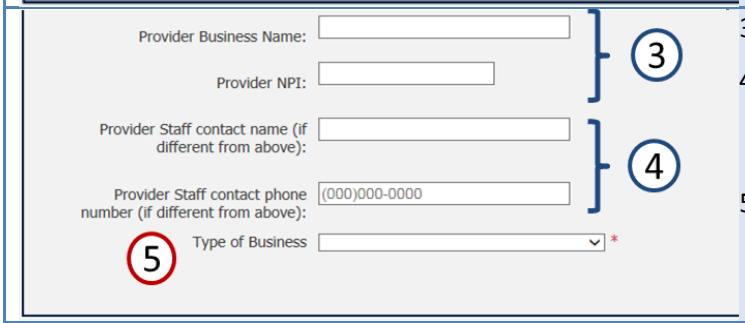
If you need assistance completing this form or wish to verbally report your issue, please call 1-877-254-1055 to speak to a Medicaid representative.

* Required fields

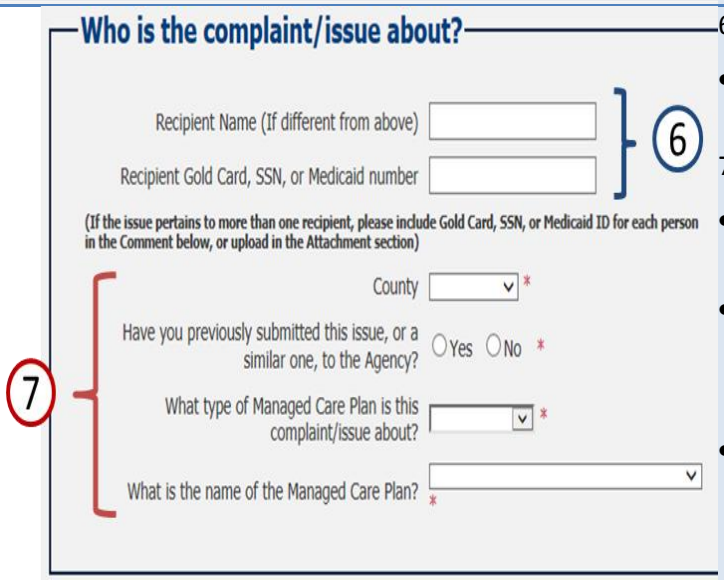


1. Enter the name, email, and phone number of the best person to be reached regarding the complaint.
2. Complete all fields with an *.

- Select **"I am a healthcare provider"**
- After selecting the type of complainant, additional fields will appear.



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.



6. Recipient details are <u>not required</u> to submit a form.

- If needed, one example can be entered, or an attached list can be uploaded.

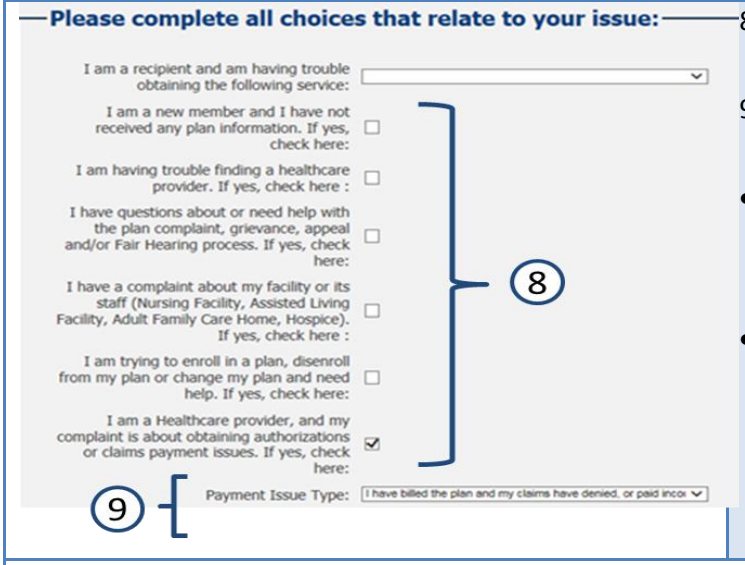
7. Complete all fields with an *.

- 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.



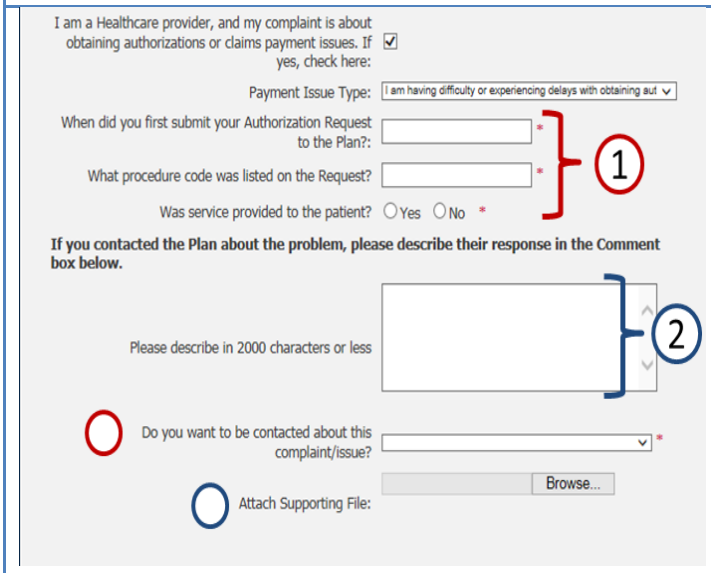
8. Choose the check box to indicate a <u>Healthcare provider</u> complaint.
9. Choose the payment issue type from the drop down menu.

- Difficulties or experiencing delays in obtaining authorization

OR

- Billed the plan and claims have denied or paid incorrectly

AUTHORIZATION COMPLAINT



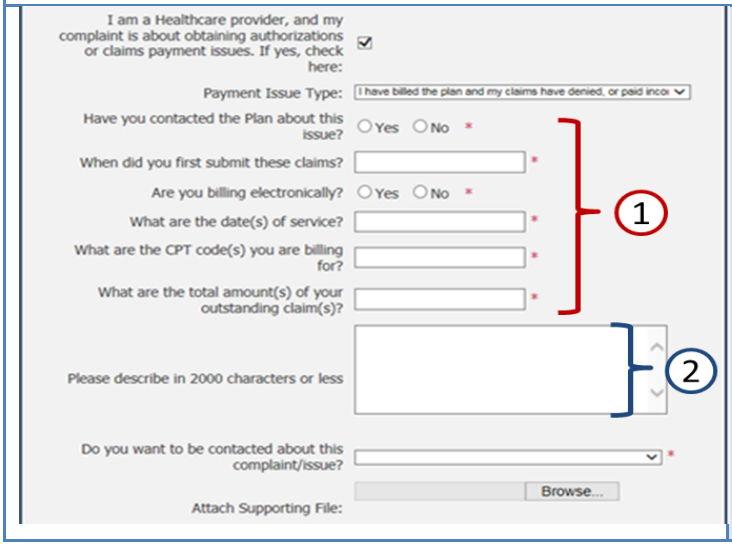
1. Complete all fields with an *

- 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



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.).