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Health Plan Oversight: Contract Monitoring Branch
Managed Care Organization Dispute Form

Dispute Form Guide (Please read before submitting a dispute):
The dispute resolution process requires providers and/or members to first utilize the Managed Care Organization's ("MCO") internal grievance and appeal process before submitting a dispute to the Kentucky Department for Medicaid Services ("KDMS"). This ensures that MCOs are given the opportunity to fully resolve the issue prior to KDMS review.

Grievances and Appeals
*Grievances and appeals submitted through the MCO process may be submitted to KDMS Dispute Resolution after **30 calendar days** have passed from the date of submission to the MCO's internal process. If KDMS determines that the MCO has not resolved the matter within this timeframe, the dispute may be submitted for further review by KDMS.*

A provider who has exhausted the MCO's internal appeal process shall have a right to a final denial determination, in whole or in part, which may then be appealed to an independent third party in accordance with applicable state and federal law. Written notification of appeal rights will be provided by the MCO. A provider who elects to appeal may file a request for a final decision by an independent third party through the Cabinet for Health and Family Services Division of Administrative Hearings. If the provider prevails, in whole or in part, the MCO shall comply with the Final Order within sixty (60) Days unless otherwise directed.

Dispute Submission
- *Under the MCO internal grievance/appeal process, MCOs are required to assign a tracking number to each case. Providers and/or members must include this tracking number when submitting the KDMS Dispute Form.*
- *Disputes that do not include the assigned tracking number cannot be reviewed and will be returned for completion.*
- *Once complete, disputes will be submitted to the MCO for timely review and resolution.*

Additional Guidance
- *Providers should use the Dispute/Claims-Issue template when submitting two (2) or more related disputes/claims with the same MCO. The template allows for up to 100 related items per submission. The template is available here (link).*

- *KDMS does not function as a collection service; however, we expect MCOs to address claims promptly and conduct thorough review of all facts related to the claim.*

What you can expect from KDMS after your dispute is accepted:

- *Send you an electronic acknowledgment within three to five (3-5) business days of receipt of your dispute*
- *Start working with the respective MCO on your dispute*
- *Check in with you within ten (10) business days of acknowledgement of your dispute*
- *The KDMS specialists will determine if the complaint was substantiated and follow up with you to discuss the outcome.*

Section 1: Contact Information *[Complete ALL fields]*	
Contact Name	
Contact Business Name	
Contact Email	
Contact Fax Number	
Contact Phone Number	
Which MCO are you filing a dispute against?	☐ Aetna BH-KY ☐ Anthem BCBS ☐ Humana ☐ United HC ☐ Passport by Molina ☐ WellCare of KY
What is your reason for filing this dispute?	☐ Denied Claim ☐ Underpaid Claim ☐ Prior Authorization Denial ☐ Credentialing ☐ Eligibility ☐ Other: *Please specify in space below*
Were any of the following methods utilized to resolve your dispute directly with the MCO? *Include all assigned ticket/tracking numbers for any method utilized, and determinations received.*	☐ *Written / Oral Grievance* Date Filed: _____ Ticket/Tracking Number: _____ ***Has there been a determination?*** ☐ Yes – when? _____ ☐ No
	☐ *Appeal* Date Filed: _____ Ticket/Tracking Number: _____

	Has there been a determination? ☐ Yes – when? _____ ☐ No
	☐ *External Independent Third-Party Review* Date Filed: _____ Ticket/Tracking Number: _____ ***Has there been a determination?*** ☐ Yes – when? _____ ☐ No
	☐ *State Fair Administrative Hearing* Date Filed: _____ Ticket/Tracking Number: _____ ***Has there been a determination?*** ☐ Yes – when? _____ ☐ No
Provide Details of MCO Contact	Date:
	Method: ☐Phone ☐Email ☐ Letter
	MCO Representative Name:
	MCO Tracking Number:
Section 2: Provider Information *[Complete ALL fields]*	
Provider Name	
Provider NPI	
Provider Specialty	
Provider Tax Identification Number ("TIN")	
Provider Business Address	
Provider Business City, State, Zip Code	
Provider Email	
Section 3: Member Information *[Complete ALL fields]*	
Member Name	
MCO Member ID	
Member Phone Number (if applicable)	
Member Email (if applicable)	
Section 4: Description of Dispute *[Complete ALL fields]*	

Provide a detailed description of your dispute. • *A clear explanation of the issue or concern.* • *Relevant dates (e.g. claim submission date, denial date, appeal submission date)* • *Identification of the MCO action or decision being disputed.* • *Any steps already taken through the MCO's grievance/appeal process.* • *Supporting details that will help clarify the matter (e.g. claim numbers, authorization numbers, correspondence references).* ***Tip**: Be as specific as possible. Providing complete information will allow KDMS and the MCO to review and resolve your dispute more efficiently.*	
Section 5: Claim Information *[Complete ALL fields if dispute is regarding claims]*	
Claim Number *If you are disputing one (1) claim, all fields must be complete in this section.* *If you are disputing two (2) or more of the same/similar claims issues, please complete and attach the Dispute/Claim-Issue template spreadsheet. Link here*	
Authorization Number (If applicable)	
Date of Service	
Date Claim Submitted to MCO	
What method was utilized to submit the claim?	☐Mail ☐Electronic
Has the MCO…	*Acknowledged Receipt of claim?* ☐ Yes – When? _____ ☐ No
	Denied receipt of claim? ☐ Yes – When? _____ ☐ No
	Made any payment? ☐ Yes – When? _____ ☐ No

	Recouped any amount on this claim? ☐ Yes – When? _____ ☐ No
	Denied the claim in writing? ☐ Yes – When? _____ ☐ No
Section 6: Desired Resolution *[Complete ALL fields]*	
Please provide a detailed description of the desired resolution.	

Section 6: Supporting Documentation *[Complete ALL fields]*	
Provider a list of attached supporting documents *(e.g., copies of the claim, EOB, prior authorization request, medical records, etc.)*	
Section 7: Dispute Certification	

I certify that the information provided in this dispute resolution form is true and correct to the best of my knowledge. I understand that any false statements can result in penalties under state and federal law.

Signature_____ Date _____

Please complete this information and submit by mail, email, or fax to:

Mail:

Division of Health Plan Oversight
Contract Monitoring Branch
Department for Medicaid Services
275 E. Main Street 6E-D
Frankfort, KY 40621

Email: ProviderMCOInquiry@ky.gov

Fax: 502-564-0223
"Attention: Contract Monitoring Branch"