KENTUCKY DEPARTMENT FOR MEDICAID SERVICES
PROVIDER COMPLAINT FORM

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

Division of Program Quality & Outcomes
Department for Medicaid Services
275 E. Main Street 6C-C
Frankfort, KY 40621

502-564-9444
502-564-0223 Fax
ProviderMCOInquiry@ky.gov

GENERAL PROVIDER INFORMATION

Provider Name: ____ **NPI #:** ____

Provider Specialty: ____

Provider's Place of Service Address: ____

City: ____ **St:** ____ **ZIP:** ____

Provider's Contact Person's Name: ____

Contact Person's Company: ____

Mailing Address: ____

City: ____ **St:** ____ **ZIP:** ____

Phone: ____ **Fax:** ____ **E-mail:** ____

Managed Care Organization (MCO) Name:

Were you a participating provider with this MCO on the dates of service? ☐Yes ☐ No

Who have you contacted at the MCO? ____

Medicaid Member's Name: ____ **Medicaid Member ID #:** ____

DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT

Please complete and submit with General Provider Information and copy this form if needed for additional dates of services.
Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: ________ **Disputed Service Line(s):** ________

Date services rendered: ________ **Date claim first sent to MCO:** ________

Sent by: ☐ **Mail** ☐ **Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters)

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No If yes, when?** ________

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** ________

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** ________

Denied the claim in writing?☐**Yes** ☐**No If yes, how much & when?** ________

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? ________ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**

Provider Name: ________ Member Name: ________ Page ____ of ____

Use this section to add additional claims with different dates of services regarding the same Medicaid Member. Please attach copies of all documentation necessary to explain and support your complaint.

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