



Provider Grievance Form

INSTRUCTIONS

CenCal Health makes a grievance resolution process available to providers in accordance with various regulations that govern the health plan. These grievances, or disputes, may take various forms, including, but not limited to, the following: "Appeals" (requests to change a previous decision, i.e. regarding Authorization Requests, Medical Authorization Requests, or claims), or "Complaints" (an expression of dissatisfaction). In order to be effectively addressed, we have provided this form for providers to use when submitting grievances to CenCal Health. If submitting a grievance please complete this form, attach all supporting documentation, and clearly describe the reason for your grievance. Grievances lacking information required for resolution will be returned to you with a request for more information.

CenCal Health requests that you file an appeal only in situations where CenCal Health has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. **Claim corrections should be submitted on a Claim Correction Form (available at www.cencalhealth.org) to our Adjudication Department.** If your claim was denied for timeliness of submittal or timeliness of follow-up, please do not submit an appeal unless you are also submitting verification of timeliness that meets criteria, OR you have a valid Delay Reason Code.

CenCal Health will acknowledge receipt of your grievance within 15 business days and send a written resolution to your grievance within 45 business days after the date of receipt.

Please submit this completed form with all supporting documentation attached to:

Grievance Type

<u>Claims</u>	<u>Complaints</u>	<u>Health Services</u>
<input type="checkbox"/> Claims Billing Dispute <input type="checkbox"/> Claims Payment Dispute <input type="checkbox"/> Claims Appeal (Appealing Dispute outcome)	<input type="checkbox"/> Provider <input type="checkbox"/> Member <input type="checkbox"/> CenCal Health <input type="checkbox"/> Other: _____	<input type="checkbox"/> TAR Appeal <input type="checkbox"/> Medical Authorization Appeal
CenCal Health 4050 Calle Real Santa Barbara, CA 93110 Attention: Adjudication Department	CenCal Health 4050 Calle Real Santa Barbara, CA 93110 Attention: Provider Services	CenCal Health 4050 Calle Real Santa Barbara, CA 93110 Attention: Health Services

Provider Name:	Billing Provider NPI:
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Provider Address:

Provider Type (specialty): <input type="checkbox"/> Physician <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> LTC <input type="checkbox"/> Vision <input type="checkbox"/> DME <input type="checkbox"/> Allied <input type="checkbox"/> Transportation

Name of person submitting grievance:	Relationship to Provider: <input type="checkbox"/> Self <input type="checkbox"/> Office Staff <input type="checkbox"/> Billing Service <input type="checkbox"/> Other: _____
Address of person submitting grievance:	

Member ID #:	Member Last Name:	Claim Control Number (CCN):
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Member Plan ID: <input type="checkbox"/> SBHI <input type="checkbox"/> SLOHI <input type="checkbox"/> PP2 <input type="checkbox"/> SBHFP <input type="checkbox"/> SLOHFP <input type="checkbox"/> SBHK <input type="checkbox"/> SLOHK <input type="checkbox"/> IHSS

Description of Grievance (please indicate specific line #'s, if applicable, and/or attach additional pages as needed and include all available supporting documentation):
