

Individual Complaint Screen Shots



Provider Complaint System

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Complaint #	PC110	Provider Name	TEST ORGANIZATION	Contact	Test User
Date Created	6/16/2015 10:50:40 AM	Complaint Type	Individual Complaint	Email	test@test.com
Created By	Test User	Complaint Status	Pending Submission to DMHC	Phone	999.999.9999

Provider	Payor	Nature of Complaint	Claim	Submit Documents	Complete	Delete
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Provider Information

Provider/Facility Name *

Provider Type *

Service Type *

Provider Tax ID *

Submitter Contact Information

Provider Contact *

Address * 1234 5th Street

City, State, Zip * Sacramento, CA 99999

Email * test@test.com

Phone * 999.999.9999

Fax

[Save](#)

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Complaint #	PC109	Provider Name	TEST ORGANIZATION	Contact	Test User
Date Created	6/15/2015 1:32:38 PM	Complaint Type	Individual Complaint	Email	test@test.com
Created By	Test User	Complaint Status	Pending Submission to DMHC	Phone	999.999.9999

Provider	Payor	Nature of Complaint	Claim	Submit Documents	Complete	Delete
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Use the form shown below to identify the health plan involved, the product involved and any RBO/Capitated Provider responsible for reimbursement of any portion of the claim.

Health Plan Information

(Include Inactive Health Plans)

Health Plan *

Product Involved * HMO PPO EPO POS Other

Contract * Do you have an existing direct contract with the health plan?
 Yes No

RBO/Capitated Provider Information

If this complaint does not involve an RBO/Capitated Provider, please press the Save button and proceed to the next Section. If your complaint involves an RBO/Capitated Provider, then please identify it.

(Include Inactive RBOs/Capitated Providers)

RBO/Capitated Provider

Contact First Name

Contact Last Name

Contact Email

Contact Phone - - ext.

Contract Do you have an existing direct contract with the RBO/Capitated Provider?
 Yes No

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Select the nature of complaint that best represents this complaint issue. Click the following link to view all the categories available: [View All Nature of Complaint Categories](#)

Main Category *

-- Select the Main Category --



Please briefly explain your dispute. If this is a claims dispute, please provide the specific reason(s) that the claim was paid or denied incorrectly and/or that the payer's determination was in error. *

Max Characters: 1,000 (1,000 remaining)

Save

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Complaint #	PC110	Provider Name	TSST ORGANIZATION	Contact	Test User
Date Created	6/16/2015 10:50:43 AM	Complaint Type	Individual Complaint	Email	tsst@tsst.com
Created By	Test User	Complaint Status	Pending Submission to DMHC	Phone	888.888.8888

Provider	Payor	Nature of Complaint	Claim	Submit Documents	Complete	Delete
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Claim Information

Start Date of Service

End Date of Service

Patient Identification #

Patient Last Name

Patient First Name

Subscriber First Name

Subscriber Middle Name

Subscriber Last Name

(Click if the claim number is not available)

Primary ICD Code

ICD Code Description

Claim # Assigned by Payor

Amount in Dispute

Billed Amount

Paid Amount

Contract Rate

PDR Exception? (Click to report a PDR exception for this claim)

Date of PDR Submission

PDR Submitted to

Has Written PDR Determination Been Received? Yes No

Date of PDR Determination

Additional Information

Was the service preauthorized? Yes No Preauth Not Required

Was the service a covered benefit? Yes No

Was the service provided on a contracted basis? Yes No

Did the claim involve the delivery of emergency or emergency on-call services? Yes No

Did the service in dispute involve contracted professional services rendered in a contracted hospital facility? Yes No

Save

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Complaint #	PC110	Provider Name	TEST ORGANIZATION	Contact	Test User
Date Created	6/16/2015 10:50:40 AM	Complaint Type	Individual Complaint	Email	test@test.com
Created By	Test User	Complaint Status	Pending Submission to DMHC	Phone	999.999.9999

Provider	Payor	Nature of Complaint	Claim	Submit Documents	Complete	Delete
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Provider must submit copies of any documentation it considers relevant to it's position and are required by the Department.

Required Documents: Explanation of Benefits (EOB) / Remittance Advice (RA), Initial Claim, Provider Dispute Resolution (PDR) Determination Letter, Provider Dispute Resolution (PDR) Submission

Additional Supporting Documents If Available: Correspondences, Email, Phone Log

Attach Supporting Documents

Document Type *

Description *

Browse for the file and click the "Upload Attachment" button. There is a 20MB size limit. Accepted Files: .pdf, .txt, .doc, .xls, .ppt, .gif, .jpg, .docx, .xlsx, .pptx

File *