Multiple Complaint Screen Shots

DEPARTMENT OF Managed Healthcare

State of California

Provider Complaint System

Logout

Home | Submit a Complaint | View Complaints | Communication | Manage Account | Help | Activity

Complaint #	MC50	**Provider Name**	TEST ORGANIZATION	**Contact**	Test User
Date Created	6/16/2015 5:21:15 PM	**Complaint Type**	Multiple Complaint	**Email**	test@test.com
Created By	Test User	**Complaint Status**	Pending Submission to DMHC	**Phone**	999.999.9999

Eligibility | Provider | Payor | Nature of Complaint | Claim | Complete | Delete

Multiple like complaints are made up of any number of similar individual claims. Use this page to submit information that is the same for all claims in the group. Please note that the "Claims" page will be used to enter information that is unique to each claim in the group.

Note: The following information must be the same for each claim in the group.

Did you submit a written appeal to the health plan's and/or the RBO/Capitated Provider's dispute resolution process? * Yes

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

Please provide a short description of the common issue or issues shared by all the claims in your group. *

Max Characters: 4,000 (*4,000 remaining*)

Please provide information on established contract rates and relevant medical codes for this claim.

Max Characters: 2,000 (*2,000 remaining*)

Save

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Provider Information

Provider/Facility Name * TEST ORGANIZATION

Provider Type * -- Select a Provider Type --

Service Type * -- Select a Service Type --

Provider Tax ID *

Submitter Contact Information

Provider Contact * User, Test

Address * 1234 5th Street

City, State, Zip * Sacramento, CA 99999

Email * test@test.com

Phone * 999.999.9999

Fax

Save

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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 * -- Select a Health Plan --

Product Involved * ○ HMO ○ PPO ○ Medicare + Choice ○ Medi-Cal ○ 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 -- Not Applicable --

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

Save

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Eligibility | Provider | Payor | **Nature of Complaint** | Claim | Complete | Delete

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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Eligibility | Provider | Payor | Nature of Complaint | **Claim** | Complete | Delete

Before the Department can commence an individual review of a complaint, the provider is required to submit the dispute to the payor's Dispute Resolution Mechanism for a minimum of 60 calendar days or until receipt of the payor's written determination, whichever period is shorter.

Add a Claim

Enter at least 2 claims and up to 25 claims.