MCO COMPLAINT

The purpose of this form is to communicate concerns that Providers have with specific Managed Care Organizations. It is our goal at the Bureau of Workers' Compensation to ensure that MCO's are complying with the terms of their agreement. We ask that before you complete this form, please consider the following:

Is the injured worker's BWC claim in a payable status?
Have you sent the bills to the appropriate MCO?
Have you allowed the MCO a reasonable time to respond?
Have you communicated in person with the MCO regarding this issue?

MCO NAME:_____ (REQUIRED) MCO # _____ (OPTIONAL)

PROVIDER NAME_____ (REQUIRED)

INDIVIDUAL TREATING PROVIDER #_____-_____

GROUP PAY-TO PROVIDER # _____-_____

PHONE NUMBER(_____)_____(REQUIRED) FAX(_____)_____

(Please complete one form per injured worker)
NAME OF INJURED WORKER _____ CLAIM # _____ DOI_____

NATURE OF COMPLAINT:

- ☐ NON PAYMENT
- ☐ LEVEL OF CUSTOMER SERVICE
- ☐ PRIOR AUTHORIZATION
- ☐ NO EOB OR UNCLEAR EOB ON REMIT
- ☐ OTHER (please briefly explain) _____

Please provide any additional information in reference to the above complaint. *(ex.- who you spoke with, when the claim was originally sent to MCO, number of submissions, number of calls placed etc.)* ***Please include the date of service and billed charges for each bill submitted. Attach additional sheets if necessary. Fax completed form to 614-728-9534.***

Name of individual completing form: _____ (please print) Date:____/____/____

Signature:_____

Title:_____ Phone Number ( ) _____ (required)

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