Community Care Plan

The Health Plan with a Heart

Dispute Resolution Process

Training **Topics**

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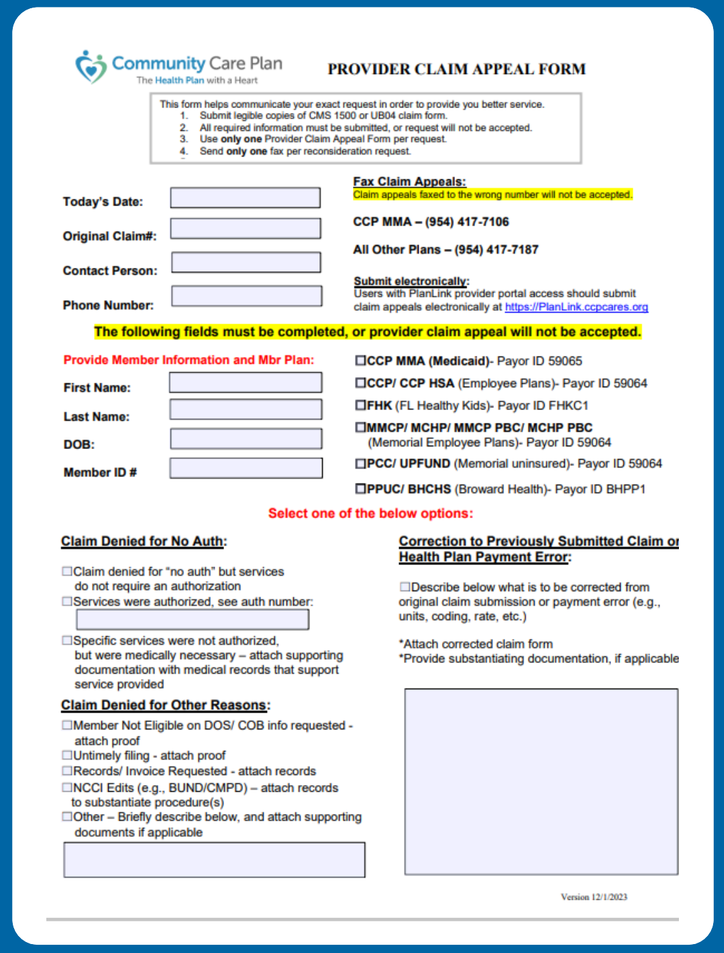
Required Documentation for a Fax Appeal



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PROVIDER CLAIM APPEAL FORM

This form helps communicate your exact request in order to provide you better service.
1. Submit legible copies of CMS 1500 or UB04 claim form.
2. All required information must be submitted, or request will not be accepted.
3. Use **only one** Provider Claim Appeal Form per request.
4. Send **only one** fax per reconsideration request.

Today's Date:
Original Claim#:
Contact Person:
Phone Number:

Fax Claim Appeals:
Claim appeals faxed to the wrong number will not be accepted.

CCP MMA – (954) 417-7106

All Other Plans – (954) 417-7187

Submit electronically:
Users with PlanLink provider portal access should submit claim appeals electronically at https://PlanLink.ccpcares.org

The following fields must be completed, or provider claim appeal will not be accepted.

Provide Member Information and Mbr Plan:
First Name:
Last Name:
DOB:
Member ID #

☐**CCP MMA (Medicaid)**- Payor ID 59065
☐**CCP/ CCP HSA** (Employee Plans)- Payor ID 59064
☐**FHK** (FL Healthy Kids)- Payor ID FHKC1
☐**MMCP/ MCHP/ MMCP PBC/ MCHP PBC** (Memorial Employee Plans)- Payor ID 59064
☐**PCC/ UPFUND** (Memorial uninsured)- Payor ID 59064
☐**PPUC/ BHCHS** (Broward Health)- Payor ID BHPP1

Select one of the below options:

Claim Denied for No Auth:

☐Claim denied for "no auth" but services do not require an authorization
☐Services were authorized, see auth number:
☐Specific services were not authorized, but were medically necessary – attach supporting documentation with medical records that support service provided

Claim Denied for Other Reasons:

☐Member Not Eligible on DOS/ COB info requested - attach proof
☐Untimely filing - attach proof
☐Records/ Invoice Requested - attach records
☐NCCI Edits (e.g., BUND/CMPD) – attach records to substantiate procedure(s)
☐Other – Briefly describe below, and attach supporting documents if applicable

Correction to Previously Submitted Claim or Health Plan Payment Error:

☐Describe below what is to be corrected from original claim submission or payment error (e.g., units, coding, rate, etc.)

*Attach corrected claim form
*Provide substantiating documentation, if applicable

Version 12/1/2023

Completed appeals form

Completed CMS 1500 or UB04 form

Please use one Provider Claim Appeal Form per request

Submit only one fax per appeal

To ensure timely processing, include all required information, as incomplete submissions cannot be accepted

Please double-check the fax number, as appeals sent to the incorrect number will not be processed

Electronic Claims Reconsideration or Appeal - Planlink

- Submit corrected claims through the PlanLink provider portal within 90 days of the original payment explanation.
- For reconsiderations or appeals, include any supporting documents as needed.
- If the decision is changed, you’ll receive an updated explanation of payment.

Submission Timeline for Appeals

90-Day Submission Guideline

- Corrected Claims: should be submitted within 90 days from the date of denial listed in the Remittance Advice (RA)
- Return of Additional Information: should also be submitted within 90 days from the denial date

Late Submissions

- If a claim or additional information is submitted after the 90-day window, the appeal may be denied with the reason code DEN3 for "reconsideration time exceeded"

Standard Claim Processing

- If the claim has not been previously denied, it will go through the standard claim review process

Electronically Submitted Claims

Acknowledgment of Receipt
- Within 24 hours after the start of the next business day

Clean Claims (Nursing Facility and Hospice)
- Action (Pay, Deny, or Contest): Within 10 business days
- If Contested: The provider will receive an itemized list of additional info needed

All Other Clean Claims
- Action (Pay, Deny, or Contest): Within 15 days
- If Contested: The provider will receive denial reasons or additional info required

For Contested Claims
- Resolution (Pay or Deny): Within 90 days
- Obligated Payment: If unresolved within 120 days, CCP will pay the claim

A clean claim satisfies all submission requirements and requires no further scrutiny. Unclean claims contain errors or omissions and may require additional information or correction before processing.

Non-Electronically Submitted Claims

Acknowledgment of Receipt

- Within 15 days after receipt, or provide electronic access to claim status

All Non-Electronic Claims

- Action (Pay, Deny, or Contest): Within 20 days
- If Contested: An itemized list of additional required info will be provided

For Contested Claims

- Resolution (Pay or Deny): Within 120 days
- Obligated Payment: If unresolved within 140 days, CCP will pay the claim

Final Decision on Appeals

Review of Submitted Documentation:

- If Approved: The claim will be reprocessed and paid.
- If Insufficient: The appeal will be denied, and you'll be notified through the Remittance Advice (RA)

Note: All decisions are final, and no further appeals will be considered

Common Reasons for Appeals Requests

- **Timely Filing:** Acceptable proof includes
  - Certified mail receipt
  - Fax confirmation
  - Printouts from provider billing systems showing date and address
- **Lack of Authorization:** Proof of prior authorization must be attached; if no authorization exists, the claim will be denied for “no authorization”
- **Miscellaneous Denials:** Submit with supporting documentation to address specific denial reasons

Non- Claims Issues

This applies to complaints unrelated to billing or claims processing, such as administrative issues and service authorizations.

You'll have multiple ways to connect with CCP staff by phone, email, regular mail, or in person to ask questions, submit complaints, and resolve any issues.

For assistance, please contact your **Provider Operations Representative**, call the **Provider Operations Hotline at 855-919-9506,** or email us at **ccp.provider@ccpcares.org**.
Dedicated CCP team members are available to receive and process provider complaints, ensuring timely support and resolution.

Examples of Non- Claims Issues

- **Service Authorization:** May experience delays or challenges in obtaining prior authorizations
- **Credentialing Delays:** Delays or administrative errors in credentialing or recredentialing
- **Provider Portal Issues:** Technical problems affecting access to information
- **Policy Clarity:** Information on guidelines, such as updates on service authorizations, clinical requirements, or documentation standards
- **Administrative Errors:** Mistakes in authorizations or patient information

Filing Non-Claims Complaints

- Providers have 45 days from the date of the issue to file a non-claims complaint
- The provider will be notified verbally or in writing within 3 business days of receiving the complaint
- The notification will include an estimated date of resolution

If the complaint remains unresolved after 30 days:

- A documented reason for the delay will be provided
- You will receive a written status update every 30 days until the complaint is resolved
- Updates will follow the standardized Notice of Status Letter Template provided by the Agency for consistency

Complaint Resolution

- All complaints will be resolved within 90 days of receipt
- You will receive a written notice with the resolution details within 3 business days once your complaint is resolved
- For questions or assistance, please contact your **Provider Operations Representative** or the Provider Operations Hotline at **855-919-9506**

Thank You

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