

Insurance Grievance (Draft)

To: Insurance Carrier (pull tab)
Address (pull tab)
Fax number (pull tab)

Name of Provider:
Provider Tax ID #:
Name of Client:
Client Insurance Identification #:
Dates of Service:
Date Initial Claim Filed:
Filed on: UB04 or HCFA (select one)

Issue/s (pull tab)

_____ Payment not made on claim, contrary to State of Ohio Law.
_____ Payment denied due to carrier stating "pre-existing condition". Client has had continuous insurance, thus, through HIPPA this is an invalid denial.
_____ Payment denied for "not receiving claim". This is contradictory, how could we receive a denial had the carrier not received the claim?
_____ Payment was made, however; was not paid at contractually agreed to rate.
_____ EOB detailed that there may be another carrier. There is none that we are aware of. Claim needs to be paid immediately or provide us data as to the other carrier.
_____ Payment requires interest (per State of Ohio law) as claim was not paid in timely fashion per State of Ohio law.

This claim and all payments due on it (including interest) needs to be paid within 10 business days of this facsimile transmission. If payment is not received within that time this grievance will automatically be filed with the State of Ohio Department of Insurance.

Sincerely,

(pull tab)

phone number (direct of biller-pull tab)