

Kentucky Medicaid MCO Provider Grievance Form

Check the box of the plan you are filing the grievance with	MCO	Phone	Fax
	<input type="checkbox"/> Anthem BCBS Medicaid	1-855-661-2028	1-855-384-4872
	<input type="checkbox"/> CoventryCares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	<input type="checkbox"/> Humana – CareSource	1-855-852-7005	1-855-262-9794
	<input type="checkbox"/> Passport Health Plan	1-800-578-0775	502-585-8340
	<input type="checkbox"/> WellCare of Kentucky	1-877-389-9457	1-866-388-1769

Please complete all appropriate fields
 If you need assistance with this form, call your MCO at the number listed above
 All Grievances must be filed within 30 days from the date of MCO action

Date _____

Provider Name _____ Address _____

City _____ State _____ County _____

NPI# _____ Email _____ Phone _____

Name of person filing Grievance _____

What is the Grievance/Complaint about?

I am having trouble with the following: (Check all that apply)

<input type="checkbox"/> Billing Policy	<input type="checkbox"/> Credentialing	<input type="checkbox"/> Provider Representative
<input type="checkbox"/> Claims Dispute	<input type="checkbox"/> Denial of Service	<input type="checkbox"/> Service
<input type="checkbox"/> Communications	<input type="checkbox"/> Eligibility	<input type="checkbox"/> Slow Payment
<input type="checkbox"/> Coordination of Benefits	<input type="checkbox"/> Excessive Wait Times	<input type="checkbox"/> Other

Please give as much detail as possible about this complaint/grievance:

Signature of person filing grievance _____ Date _____