

Ohio Department of Insurance

John R. Kasich – Governor
 Mary Taylor – Lt. Governor/Director



Third Party Payer

This form is to be completed by the third-party payer

The third-party payer shall complete and submit this form to the Department within 15 working days. Prior to completing this form, the third-party payer shall contact the provider directly and resolve all issues stated in the complaint. Please contact Consumer Services at 800-686-1526 if there are any questions.

Please enter Complaint Number you are responding to: _____

Please Enter Resolution Details Below:

Has your company contacted the provider about this complaint? Yes No

Type of insurance Group Health Individual Health Dental
 Self Funded Vision Government Programs

Complaint Disposition (Choose One):

- | | |
|--|---|
| <input type="checkbox"/> Prior Denial Upheld
<input type="checkbox"/> Claim Previously Not Processed—payment issued
<input type="checkbox"/> Not a Member
<input type="checkbox"/> Waiting for Information from External Source (see below) | <input type="checkbox"/> Prior Denial Reversed—payment issued
<input type="checkbox"/> Claim Previously Not Processed—payment denied
<input type="checkbox"/> Appeal/Previous Written Contact Not Initiated by Provider |
|--|---|

Date Claim Received: _____ **Date Claim Paid or Denied (if applicable):** _____

Covered:	Not Covered:	Contractual Adjustment:	Deductible:	Payment:	Insured's Responsibility:
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*** Required (if applicable):**
Additional amount paid as a result of this complaint or after the complaint was filed: _____

If the claim(s) in question remain(s) denied or not covered in full (other than deductible / coinsurance), please indicate the appropriate reason(s) below:

- | | |
|---|---|
| <input type="checkbox"/> Benefit Maximum Met
<input type="checkbox"/> Claim Paid in Error / Recovery Issue
<input type="checkbox"/> Coordination of Benefits
<input type="checkbox"/> Member / Patient Not Eligible
<input type="checkbox"/> Out of Network – Reduced Benefits Applied
<input type="checkbox"/> Pre-Existing Condition | <input type="checkbox"/> Claim Filing Time Limit Exceeded
<input type="checkbox"/> Coding Issue
<input type="checkbox"/> Medicare Liability
<input type="checkbox"/> Other (provide comments below)
<input type="checkbox"/> Patient Not Our Member
<input type="checkbox"/> Worker's Compensation Liability |
|---|---|

If you are waiting for information, please indicate from whom below:

- | | |
|---|---|
| <input type="checkbox"/> Employer
<input type="checkbox"/> Other external source (explain in comments) | <input type="checkbox"/> Member / Patient
<input type="checkbox"/> Submitting Provider |
|---|---|

Other Comments: _____

Third-party payer Contact Information:

Person who completed this form _____ Date _____
 Title _____ Phone # _____
 Fax # _____ E-mail _____
 NAIC number (Federal identification number if no NAIC #) _____