

Grievance, Appeal and Dispute Request Form

Please complete this form and send by fax or mail:

Fax: 910-839-8320

Mailing address: Troy Medicare, PO Box 1265, Westborough, MA 01581

For both standard and expedited requests, the following guidelines apply:

Discussion Time of Cristiana Annual or Discussion and submitting

Per CMS and Troy Policy, requests must be filed within 60 calendar days from the date of the incident or date of the notice of the initial determination. For requests received after the 60-day filing timeframe, please provide good cause exceptions for late filing.

Please select Type of Grievance, Appeal or Dispute You are submitting:	
Member Grievance Member Appeal - PreService/Auth Member Appeal - PostService/Claim	
Troy Contracted Provider Claim Dispute Troy Contracted Provider PreService/Auth Appeal	
NonPar Provider Appeal - PostService/Claim* NonPar Provider Appeal - PreService/Auth	
TODAY'S DATE:	
MEMBER INFORMATION	
MEMBER NAME: MEMBER ID#	
MEMBER REPRESENTATIVE (if applicable):	
MEMBER DATE OF BIRTH:MEMBER or REPRESENTATIVE PHONE #:(plea	se specify)
MEMBER ADDRESS:	
PROVIDER INFORMATION (IF APPLICABLE TO THE COMPLAINT OR APPEAL):	
PRIMARY CARE PHYSICIAN (PCP):	
FACILITY NAME:	
PHONE NUMBER:	
SPECIALIST/PROVIDER NAME:	
SPECIALIST PHONE NUMBER:	
FOR AN <u>APPEAL or CLAIM DISPUTE</u> , LIST SERVICE, ITEM, OR PAYMENT REQUEST THAT WAS DENIED (NOTE: Include submission supporting documentation available such as EOP, EOB, medical records or any other materials that so your request for reconsideration):	
SERVICE OR ITEM(S) DENIED:	
IF DENIED CLAIM, LIST CLAIM NUMBER**	
DATE(S) OF SERVICE(S) DENIED:	
DME AND/OR DRUG(S) DENIED:	
PAYMENT REIMBURSEMENT DENIED AMOUNT:	
DATE YOU RECEIVED THE DENIAL FROM TROY:	

PLEASE SIGN AND DATE PAGE 2

^{*}Providers that are not contracted with Troy Medicare (NonPar Providers) must complete and sign a Waiver of Liability (WOL) form for any PostService/Claim Appeals.

^{**} FOR BETTER PROCESSING, PLEASE COMPLETE AND SUBMIT SEPARATE FORMS FOR EACH CLAIM OR AUTH DENIAL. NOTE: DO NOT USE THIS FORM FOR AN APPEAL ABOUT A PART D PRESCRIPTION DRUG. SEE PRESCRIPTION DRUG REDETERMINATION (APPEAL) FORM.



DATE OF INCIDENT:	
PLEASE DESCRIBE YOUR COMPLAINT or FOR APP	EALS/PAYMENT DISPUTES, PLEASE PROVIDE REASON FOR YOUR
REQUEST FOR RECONSIDERATION (Please include	e any supporting documentation in support of your request):
Submitter SIGNATURE:	DATE:
	ompleting this form, please include appropriate AOR or
appointment document and sign.)	

If you have any questions or need help in completing this form, please contact
Member Services at 1-888-494-TROY (8769) or TTY 711. We are available 8am-8pm 7 days a week from
October through March, and Monday-Friday from April through September.