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:
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 #: _____ (please 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 APPEAL or CLAIM DISPUTE, LIST SERVICE, ITEM, OR PAYMENT REQUEST THAT WAS DENIED (NOTE: Include in your submission supporting documentation available such as EOP, EOB, medical records or any other materials that support 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.

Troy
MEDICARE

DATE OF INCIDENT: _____

PLEASE DESCRIBE YOUR COMPLAINT or FOR APPEALS/PAYMENT DISPUTES, PLEASE PROVIDE REASON FOR YOUR REQUEST FOR RECONSIDERATION (Please include any supporting documentation in support of your request):

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Submitter SIGNATURE: _____ DATE: _____

(If an authorized representative of a member is completing 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.