PROVIDER RELATIONS

Call Center and Correspondence

Forms

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Call Center and Correspondence Forms

Request for Provider Contact Form (Transfer a provider visit request to the field analyst)

Provider Request Form (To request printed materials, manuals, training pkts, claim forms, etc.)

History Request Form (To request a provider history for the provider)

Request for Remittance Advice Form (To request an RA for a provider)

Lost Check Inquiry Worksheet (To route information concerning a lost check)

Memorandum – TPL Unit (To report possible problems on the Resource File to TPL Unit)

Memorandum – DHH/MMIS Claims Resolution (To report possible problems on the Recipient File to Eligibility/MMIS Claims Resolutions)

Precert Routing Form (To request precert review for professional claims where no precert obtained by hospital)

Request for Medical Review (To request review of a particular claim by the Medical Review staff)

Request for Provider Contact Form

REQUEST TYPE: ○ STATE ○ UNISYS ○ PROVIDER ○ OTHER

PROVIDER NUMBER: TRACKING NO:

PROVIDER NAME:

ADDRESS: ☐ Change Address

CITY: STATE: ZIP:

TELEPHONE NUMBER: - - ext.

CONTACT PERSON: DARLENE

If State Request, STATE REQUESTER:

NATURE OF PROBLEM(S):

COMMENTS:

FIELD REP NAME:

ORIGINATOR'S NAME: DATE REQUESTED:

PROCESSED BY: DATE PROCESSED:

COMPLETED BY: DATE COMPLETED:

Save Field Rep Request

Provider Request Form

TRACKING NO: 911910403

☐ MANUAL TYPE:

☐ TRAINING TYPE: MON: YEAR:

☐ TPL LISTING TYPE: ○ ALPHA ○ NUMERIC

☐ FEE SCHEDULE TYPE: ○ DEM ○ PROFESSIONAL

☐ ENROLLMENT TYPE:

If CommunityCare, indicate parish: Is claim type 13 already on provider file? ○ Y ○ N

☐ PE50 ☐ CP-0-92 ☐ RS-0-07 ☐ OTHER

☐ 102 REHAB SVCS ☐ 209 DENTAL EPSDT-ADJ ☐ 205 AMBUL TRANS ADJ.

☐ 105 AMBUL TRANS ☐ 210 DENTAL ADULT-ADJ ☐ 206 NON-AMB TR ADJ.

☐ 105 TRANSP ATT ☐ 213 AMA ADJUSTMENT ☐ 212 LTC ADJ

☐ 106 NON-AMB TR ☐ 202 REHAB SVCS ADJ. ☐ KM-3

☐ 148 PLI ADJUSTMENT

☐ 158 A ☐ PA 01 ☐ PA 02

Edit Address: ☐

PROVIDER NUMBER: - Lookup PROVIDER NAME:

ATTENTION: CALLER PHONE - - Ext

PROVIDER ADDRESS:

City: State: Zip:

ORIGINATOR: DATE OF REQUEST:

Comments/Instructions:

Submit Request

History Request Form

PROVIDER NUMBER: Lookup TRACKING NO:

PROVIDER NAME:

ATTENTION:

ADDRESS:

Change Address CITY: STATE: LA ZIP:

TELEPHONE NUMBER: - - ext.

CONTACT PERSON: DARLENE

HISTORY:

Mail to Provider Research

COMMENTS:

PHONE REP: DATE REQUESTED:

Submit Request

Request for Remittance Advice Form

PROVIDER NUMBER: Lookup TRACKING NO:

PROVIDER NAME:

ATTENTION:

ADDRESS: Change Address

CITY: STATE: ZIP:

TELEPHONE NUMBER: - - ext.

CONTACT PERSON: DARLENE

DATE OF R/A (MM/DD/YYYY):

Add R/A Date

Note: If (# Of Pages) field is filled and (Date) field is empty or (Date) field is filled and (# Of Pages) field is empty, then that row is invalid.

FEE REQUIRED: Yes No

SPECIAL INSTRUCTION:

SIGNATURE: DATE REQUESTED:

Submit R/A Request

Lost Check Inquiry Worksheet

DATE:

PERSON INQUIRING: PHONE: - - -

PROVIDER NUMBER: TRACKING NO:

PROVIDER NAME:

PAY-TO NAME:

PAY-TO ADDRESS:

City: State: Zip:

CYCLE DATE MISSING: UNISYS EMPLOYEE:

CHECK NUMBER: CHECK AMOUNT: $

Submit

UNISYS

MEMORANDUM

To: BHSF, TPL Unit

From: Unisys, Provider Relations Unit

Date:

Log#:
Provider Name:
Provider Number:
Recipient Name:
Recipient Number:
Date of Service:
Please update the Third Party Liability Resource File due to the following:

1. ☐ **TPL not on resource file.**
2. ☐ **TPL discontinued**
3. ☐ **Scope of coverage requires review.**
4. ☐ **Medicare Part (A/B)____not on file.**
5. ☐ **Medicare coverage requires review.**
6. ☐ **Medicare claim number discrepancy.**
7. ☐ **Review the QMB indicator for the period of .**
8. ☐ **Recipient Medicaid number needs to be linked to the Medicare number.**
9. ☐ **Other:**

Signature:

State Reply: _____

_____

_____

Signature: _____Date: _____

Unisys

MEMORANDUM

To: DHH/Claims Resolution
From: Unisys, Provider Relations Unit

Date:
Log#:
Provider Name:
Provider Number:
Recipient Names:
Recipient Number:
Date of Service:
Please update the eligibility file due to the following:

1. ☐ Recipients ___ is not on our file.
2. ☐ Name/Number mismatch.
3. ☐ Recipient loaded as Male: should be female.
4. ☐ Recipient loaded as Female: should be male.
5. ☐ Not eligible on dates of service.
6. ☐ Other:

Signature:

State Reply:_____

_____

_____

Signature:_____Date:_____

PRECERT ROUTING FORM

DATE:

TO:

FROM:

LOG #:
Provider:
Recipient:
DOS:
Please review the attached claims for a 171 override.

☐ **Baby Claims**

☐ **No hospital precert on file**

☐ **Precert/Extension denied untimely (026,524)**

☐ **Other :**

REQUEST FOR MEDICAL REVIEW

DATE: _____

TO: _____

FROM: _____

PROVIDER #: _____

RECIPIENT #: _____

NATURE OF PROBLEM (s):

_____

_____

_____

_____

_____

_____

_____

_____