Prestige HEALTH CHOICE®
Leading the Way to Quality Care

Provider Complaint Form

This form will help ensure that your complaint is processed as efficiently and effectively as possible. Please fill out the form completely and mail to:

Prestige Health Choice, Attn: Provider Complaints, P.O. Box 7366, London, KY 40742

Fax: 1-855-358-5853

STOP! DO NOT USE THIS FORM IF:

1. You are submitting a corrected claim.
2. A claim was denied for failure to attach one of the following items (please submit a new claim directly to the Claims department with the requested information):

☐ Primary Explanation of Benefits ☐ Medical records ☐ Itemized bill ☐ Sterilization/consent form

This is not a complaint and should not be sent to the Provider Complaints department.

Member information	
Name:	Medicaid ID:

Provider information	
Name:	Medicaid ID:
Taxpayer Identification Number (TIN):	National Provider Identifier (NPI):

Submitter contact information	
Name:	Phone number:
Fax number:	Address:

Claim information (for multiple claims, please list on a separate page)	
Claim number:	Date of service:
Billed amount:	Remittance advice date*:

*Complaints must be received within 90 days of the remittance date to be considered for review.

Please select the reason for your complaint:

☐ Service is not a duplicate (please provide details below)

☐ Claim denied due to a clinical and/or coding edit

☐ Claim denied for no authorization — authorization # _____ was obtained

☐ Claim is underpaid — expected payment amount is: $_____

☐ Claim denied for timely filing — proof enclosed

☐ Claim denied for no allowable

Please provide details and/or calculation of expected payment amount (include copy of contract if applicable).

☐ Other: _____

_____