

**SUFFOLK COUNTY MEDICAL SOCIETY
INSURANCE COMPANY HASSLE FORM**
(Physician confidentiality will be maintained)

Please complete one form for each claim problem you are reporting to us. Include TWO COPIES of related CMS 1500 Forms (HCFA 1500) in addition to any correspondence between your office and the insurance company related to this claim. HIPAA Regulations require the SCMS to have a signed "Business Associate Agreement" on file for your office. If we do not already have one on file, we will mail it to you for signature.

PHYSICIAN NAME: *(Please print)* _____

SPECIALTY: _____

ADDRESS: _____
City State Zip

TELEPHONE #: _____ EXT. _____ FAX #: _____ E-MAIL: _____

PATIENT NAME: _____ DATE OF SERVICE (DOS): _____

INSURANCE CO. PATIENT I.D. #: _____

AMOUNT IN DISPUTE: \$ _____ INSURANCE CO. CLAIM #: _____

NAME OF PERSON COMPLETING THIS FORM: _____

(* Please complete the above in its entirety.

INSURANCE COMPANY INVOLVED (Check one)

- | | | |
|-------------------------------------------------------|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Aetna/US Healthcare | <input type="checkbox"/> GHI | <input type="checkbox"/> Multiplan |
| <input type="checkbox"/> Cigna Health | <input type="checkbox"/> Health First PHSP, Inc. | <input type="checkbox"/> Oxford Health Plans |
| <input type="checkbox"/> Empire BC/BS | <input type="checkbox"/> Magnacare | <input type="checkbox"/> Vytra Healthcare/HIP |
| <input type="checkbox"/> Empire Blue Choice Healthnet | <input type="checkbox"/> MDNY Healthcare | <input type="checkbox"/> Other _____ |

INSURANCE COMPANY HASSLES (Check those that apply)

- | | |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Claim Never Received by Carrier | <input type="checkbox"/> Recoding/Downcoding of Billed Services |
| <input type="checkbox"/> Resubmission of Claims (# of times) | <input type="checkbox"/> Repeated Request for Patient Information |
| <input type="checkbox"/> Denial of Claim (Reason) | |
| <input type="checkbox"/> Denial of Claim with Appropriate Referral | <input type="checkbox"/> Pre-Certification/Pre-Authorization |
| <input type="checkbox"/> Claim Submitted on Time-Denied as Exceeding Time Limits | <input type="checkbox"/> Pre/Post Payment Review |
| <input type="checkbox"/> Requests for Claims Documentation | <input type="checkbox"/> Questions of Medical Necessity |
| <input type="checkbox"/> Requests for Medical Records | <input type="checkbox"/> Excessive Telephone Hold Time |
| <input type="checkbox"/> Requests for Hospital Records | <input type="checkbox"/> Telephone Continuously Busy |
| <input type="checkbox"/> Other <i>(Please explain)</i> : _____ | |

Please provide any additional information that would be helpful in documenting the nature of the hassle.

**Mail or fax copy of this form and TWO COPIES of supporting documentation to:
Suffolk County Medical Society, 1767-14 Veterans Memorial Highway, Islandia, NY 11749
Fax#: 631-851-1212**