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)

- ❑ Aetna/US Healthcare
- ❑ Cigna Health
- ❑ Empire BC/BS
- ❑ Empire Blue Choice Healthnet
- ❑ GHI
- ❑ Health First PHSP, Inc.
- ❑ Magnacare
- ❑ MDNY Healthcare
- ❑ Multiplan
- ❑ Oxford Health Plans
- ❑ Vytra Healthcare/HIP
- ❑ Other __________________

INSURANCE COMPANY HASSLES (Check those that apply)

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

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

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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