MCO Primary Care Provider -Incentive Payment Program
Payment Review Action Request Form

Print Form

INSTRUCTIONS:
Rendering Provider: Please fully complete all portions of this form and return with supporting documentation to your respective Medicaid Health Plan appeals coordinator.

The Medicaid Health Plan shall review appeal and upon no resolution submit to State of Michigan Project Manager for further review.

Issue Items - All Items Must Be Completed

PayCycle:

Date of Service Quarter

Verification Deadline

Payment Date Validated by Health Plan?

If Provider appeal, has Health Plan reviewed internally?

Requestor Information

Date of Request

Health Plan

Requested BY:

Contact Name

Contact E-Mail:

Contact Phone:

ISSUE TYPE (CHECK ONE ONLY)

☐ Accounting Issue (Rate application, calculation issue, Timing Issue Current v. Residual, Etc.)

☐ Volume Issue/Data Missing (Charges/Paid Amounts Too Low/Missing Claims Data)

ISSUE SUMMARY; INCLUDE CELL RANGE REFERENCE INFORMATION IF INCLUDING DATA WORKBOOKS

SUMMARY

FOR DCH USE ONLY

Received

Ticket#