

# Claims Escalation Research & Resolution Form



**NOTE:** This claims resolution process is not available to health systems with regularly scheduled operational JOC's.

<b>Ticket Number</b> (from Provider Services) Must include Ticket # to be reviewed					
<b>Type of Issue/ Incident</b>	<b>Medical</b>		<b>Behavioral Health</b>		
<b>Issue/Incident Identified</b>					
<b>Product</b>	Ambetter <input type="checkbox"/>	Behavioral Health <input type="checkbox"/>	Medicaid <input type="checkbox"/>	Medicare <input type="checkbox"/>	MyCare <input type="checkbox"/>
<b>Date submitted to Claims Escalation</b>					
<b>Claim Number(s) Impacted</b>					
<b>Member Name(s)</b>					
<b>Member ID Number(s)</b>					
<b>Provider Name</b>					
<b>TIN/Individual NPI/Group NPI:</b>					
<b>Date(s) of Service</b>					
<b>Procedure Code(s)</b>					
<b>Authorization Number</b>					
<b>Check Number</b> (Attach correct remit address & W9)					

**NOTE:** If multiple claims/members/check numbers are applicable to your issue/incident, please attach spreadsheet with each date of service, member ID# and member date of service, along with your Claim Escalation Form.