Ohio Department of Medicaid

Managed Care Entity
Claims Denial Resource Grid

Ohio Department of Medicaid

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Drafted 8/2023. The information provided is subject to change. Providers should check their contracts or contact the managed care entity (MCE) for the most up to date information.

Aetna OhioRISE

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied claim whether clinical or non-clinical. This process must be exhausted prior to requesting external medical review (EMR) for claims with a clinical component.	Materials, Forms and Helpful Links for Providers| OhioRISE – Aetna Better Health (Click link to the provider manual and search)	Phone: 1-833-711-0773 Mail: Aetna Better Health of Ohio PO Box 81040 5801 Postal Road Cleveland, OH 44181 Online: https://apps.availity.com/availity/Demos/Registration/index.htm	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes. Within 15 business days for all other claims disputes.	Provider Services Phone: 1-833-711-0773	https://www.aetnabetterhealth.com/ohiorise/providers/index.html

AmeriHealth Caritas Ohio

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied claim whether clinical or non-clinical. Must be exhausted prior to requesting external medical review (EMR).	https://www.amerihealthcaritasoh.com/provider/forms/index.aspx. (Click link to the provider manual and search)	Phone: 1-833-644-6001 Mail: AmeriHealth Caritas Ohio Attn: Claims Processing Department PO Box 7104 London, KY 40742 Online: NaviNet: With the claims adjustment inquiry function. https://navinet.navimedix.com/plan-central/acoh Fax: 1- 833-216-2272	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes. Within 15 business days for all other claims disputes.	Provider Services Phone: 1-833-644-6001 Provider Services Fax: 1-833-643-2901	N/A

Anthem Blue Cross and Blue Shield

Clinical Claim Only
Non-Clinical Claim Only
Applicable to Both

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied clinical claim. Must be exhausted prior to requesting external medical review (EMR).	Home | Anthem Blue Cross and Blue Shield (Click link to the provider manual and search)	Phone: 1-844-912-1226 Mail: Anthem Blue Cross and Blue Shield Payment Dispute Unit P.O. Box 62500 Virginia Beach, VA 23466-1599 Online: www.Availity.com	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes.	Provider Services phone: 1-844-912-1226 Status of the case can be found provider portal (Availity) by searching case number.	Providers must submit their supporting medical documentation and the extenuating circumstance explaining why the authorization was not attached prior to services being rendered.
You are disputing a denied or partially denied non-clinical claim.		Fax (Clinical Claims): 1-866-587-3316		Within 15 business days.		

Buckeye Community Health Plan

Clinical Claim Only
Non-Clinical Claim Only
Applicable to Both

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied clinical claim. Must be exhausted prior to requesting external medical review (EMR).	Manuals, Forms and Reference Tools | Buckeye Health Plan (Click link to the provider manual and search)	Phone: 1-888-296-8731 Mail: Medicaid Buckeye Health Plan Attn: Dispute Department P.O. Box 6200 Farmington, MO 63640-3800 Behavioral Health Medicaid Buckeye Health Plan Attn: BH Dispute Department P.O. Box 6150 Farmington, MO 63640-3800 Online: Provider Web Portal (Quickest option)	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes.	Provider services phone: 1-888-296-8731	Complete a Medical Necessity Dispute Review Form located on Buckeye Health Plans Website
You are disputing a denied or partially denied non-clinical claim.				Within 15 business days.		Ensure that any associated documentation is attached if needed for the review using one of the supported document types: .jpg, tif, PDF, and tif. For quicker turnaround times, submit the dispute through the Provider Web Portal.

CareSource Ohio

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied claim whether clinical or non-clinical. This process must be exhausted prior to requesting external medical review (EMR) for claims with a clinical component.	Provider Manual | Ohio – Medicaid | CareSource (Click link to the provider manual and search)	Phone: 1-800-488-0134 Online: CareSource.com > Login > Provider Portal. From the Claims menu, select Claim Disputes or Fax: 1-937-531-2398	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes. Within 15 business days for all other claims disputes.	Provider services phone: 1-800-488-0134	N/A

Humana Healthy Horizons in Ohio

Clinical Claim Only
Non-Clinical Claim Only
Applicable to Both

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied clinical claim. Must be exhausted prior to requesting external medical review (EMR).	Medical Record Review Dispute Policy - Humana	Phone: 1-800-438-7885 Mail: Humana Provider Payment Integrity Disputes P.O. Box 14279 Lexington, KY 40512-4279 Fax: 1-888-815-8912 Online: Humana's provider portal	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes.	Provider services phone: 1-800-438-7885 Fax: 1-888-815-8912 Mail: Humana Provider Payment Integrity Disputes P.O. Box 14279 Lexington, KY 40512	N/A
You are disputing a denied or partially denied non-clinical claim.	Provider Documents and Resources | Ohio Medicaid for Providers | Humana (Click link to the provider manual and search)	Phone: 1-877-856-5707 Mail: Humana Healthy Horizons in Ohio Provider Claims Dispute P.O. Box 14601 Lexington, KY 40512-4601		Within 15 business days.	Provider services phone: 1-877-856-5707 or your provider contracting representative.	

Molina Healthcare of Ohio

Clinical Claim Only
Non-Clinical Claim Only
Applicable to Both

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied clinical claim. Must be exhausted prior to requesting external medical review (EMR).	Medical Authorization Appeal and Claim Dispute Reference Guide	Online: Submitting a clinical claim dispute and supporting clinical documentation through the Availity Essentials Portal Fax: Authorization Reconsideration Form and supporting clinical documentation to fax number 1-800-499-3406.	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes.	Provider services phone: 1-855-322-4079 (7 a.m.- 8 p.m. ET Monday to Friday).	A denied authorization (prior authorization or retro-authorization for extenuating circumstances) must be on file to qualify for a Clinical Claim Dispute. If a Clinical Claim Dispute results in an adverse determination, the provider qualifies for external medical review (EMR). If the provider calls Molina's provider services, the provider will be advised it's advantageous to submit via Portal or Fax, or to send their clinical documentation in follow-up via fax or portal.
You are disputing a denied or partially denied non-clinical claim.	Claim Dispute Reference Guide	Phone: 1-855-322-4079 (7 a.m - 8 p.m. ET Mon-Fri) Online: www.availity.com Fax: Completing and faxing the Claim Reconsideration Form to fax number 1-800-499-3406		Within 15 business days.		

Molina Healthcare of Ohio (Retro-Authorization for Extenuating Circumstances)

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
If a Retro-Authorization request for Extenuating Circumstances results in an adverse determination, the provider qualifies to request a Clinical Claim Dispute.	Medical Authorization Appeal and Claim Dispute Reference Guide	Phone: 1-855-322-4079 (7 a.m.- 8 p.m. ET Monday to Friday) Online: Submitting a clinical claim dispute and supporting clinical documentation through the Availity Essentials Portal at provider.molinahealthcare.com. Fax: Authorization Reconsideration Form and supporting clinical documentation to fax number 1-800-499-3406.	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes.	Provider services phone: 1-855-322-4079 (7 a.m. - 8 p.m. ET Monday to Friday).	N/A

UnitedHealthcare Community Plan of Ohio

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing a denied or partially denied claim whether clinical or non-clinical. This process must be exhausted prior to requesting external medical review (EMR) for claims with a clinical component.	Community Plan Care Provider Manuals for Medicaid Plans By State | UHCprovider.com (Click link to the provider manual and search.)	Phone: 1-800-600-9007 Online: UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: UnitedHealthcare Provider Portal Resources | UHCprovider.com New users: UHCprovider.com > New User and User Access. Mail: UnitedHealthcare Community Plan P.O. Box 8207 Kingston, NY 12402	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes. Within 15 business days for all other claims disputes.	Provider services phone: 1-800-600-9007	N/A

UnitedHealthcare Community Plan of Ohio (First Claim Reconsideration)

Provider Claim Dispute (PCDR) Process	Where can this information be found?	How is this process requested?	Timeframe for requesting	Timeframe for resolution	Who to contact with questions	Additional Information
You are disputing the denial of the first claim reconsideration above whether clinical or non-clinical..	https://www.uhcprovider.com/en/claims-payments-billing.html?cid=none Community Plan Care Provider Manuals for Medicaid Plans By State | UHCprovider.com (Click link to the provider manual and search.)	Phone: 1-800-600-9007 Online: Use the Claims tool in the Provider Portal. To access the portal, go to UHCprovider.com, then Sign In or go to UHCprovider.com/claims Mail: UnitedHealthcare Community Plan Grievance/Appeal Coordinator P.O. Box 31364 Salt Lake City, UT 84131	Within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	Within 30 business days for medical-necessity related claims disputes. Within 15 business days for all other claims disputes.	Provider services phone: 1-800-600-9007	N/A