

Provider Ombudsman Issue Form

Purpose: Use this form to request assistance from the NC Medicaid Provider Ombudsman.

Date:

Contact information of person submitting form:

- Name:
- Email:
- Phone:
- Title:
- Name of Organization:
- Group NPI Number:

Provide detailed description of issue:

If applicable, list other entities involved in issue (CIN, PHP, NCTracks, etc.):

What actions have already been done to try to resolve this issue? Be specific and include dates, times and any reference numbers for calls/tickets:

Briefly describe the impact on clinical care and/or revenue:

Type of Issue: Clinical Payment Claim Denial Provider Issue

Other (explain):

Email this form with attached supporting documentation to the ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov. Remove patient health and demographic information.

Recruit, Train, and Retain: Developing the workforce for a healthy North Carolina

NC AHEC Program | 145 N. Medical Drive, Chapel Hill, NC 27599 | ncahec.net | 919-966-5830
Mountain Area Health Education Center (MAHEC) developed this form and it was approved by NC Medicaid.