Payer Policy Feedback Form

Please Provide the Following Information

Physician Name: _____

Practice Name: _____

Office Phone Number: _____

E-mail: _____

Contact Person (If Different From Above): _____

Name of Health Plan You are Having Difficulty With: _____

Service/CPT Code: _____

Type of Problem: Please check all that apply.

Denial of claim ____
Denial during pre-authorization ____
Burdensome pre-authorization process ____
Other: Please be specific ____

Please email your completed form to info@scct.org.