Provider Complaint Form Guidance

The Ohio Department of Medicaid (ODM) maintains a managed care provider complaint form. This can be used by any provider who has first attempted to work directly with the plan but has been unsuccessful in getting an appropriate response. Managed care plans receive these complaints directly, in real time, and have 15 business days to respond to ODM and the provider.

ODM staff review the complaints to verify whether the plan has contacted the provider and given an answer to their question(s). ODM staff cannot arbitrate between the plan and providers. Providers are encouraged to utilize the appeals, grievance, or arbitration processes as outlined in their individual contract with the plan.

Please note: ODM does not follow-up with providers on all complaints submitted. Issues are tracked by ODM to identify trends. The form is located here.

Submission Tips:

Providers have the ability to add attachments directly into the provider complaint form.

If multiple individuals are affected by a single issue with a plan, the provider should submit only one complaint for all individuals, however; up to 5 attachments may be uploaded on a single complaint.

Adding the most recent call reference number from the plan to your complaint may help reduce the time needed to address the issue.

The plans may require additional time to research and/or resolve a specific issue; they may request an extension to the due date and have been asked to contact the provider to advise of the delay.

In the event there is a reoccurrence of a previously resolved complaint, providers should submit a new complaint, mark the question “Is this complaint related to any previously submitted complaints?” on the complaint form as yes, and enter the previous complaint’s number.