Claim Complaint Submission Guidelines

At Magellan Complete Care of Florida, your satisfaction is very important to us, and we make every effort to successfully resolve all complaints. To submit a claim complaint, complete the attached dispute form along with all applicable supporting documentation (i.e. proof of timely filing, authorization number) and send it to:

Magellan Complete Care of Florida
Claim Disputes Department
P.O. Box 1005
Maryland Heights, MO 63043

Claim complaints must be received in writing within **90 days** from the **date listed on the primary payer's final determination.**

Please use one dispute form per claim and complaint reason. If you are disputing more than 5 claims and prefer to send a spreadsheet, please include the information requested on the form in your spreadsheet and ensure you are providing an explanation for each item.

Within 3 business days of receiving your claim complaint, an acknowledgement letter will be mailed to you. We will provide written notice of the status of your complaint every 15 days thereafter. Claim complaints will be resolved within 60 days of receipt. A claim dispute resolution letter with the disposition of the complaint will be mailed to the rendering provider's address listed on the claim.

If you have any questions or need further assistance, please contact Provider Services at 1-800-327-8613, Monday – Friday from 8 a.m. to 7 p.m. Eastern time.

Claim Dispute Form

Provider name:

Provider Tax ID#:

Provider phone:

Provider email:

Member name:

Member Medicaid ID# (10 digits):

Member date of birth:

Patient account #:

Magellan Complete Care Claim #:
(from Explanation of Payment)

Dates of service:

Total claim charges:

Paid amount: *(if any)*

Amount expected to be paid:

Reason each claim is being disputed

Example: Claim 12345 – underpaid at $100; contracted rate is $500
Example: Claim 98765 – denied for no authorization but authorization was obtained (auth# IP123456789)

Magellan COMPLETE CARE®