Skilled Nursing Facility Workforce & Quality Incentive Program (SNF WQIP) – Provider Grievance Form

Filling out the Alameda Alliance for Health (Alliance) Skilled Nursing Facility Workforce & Quality Incentive Program (SNF WQIP) – Provider Grievance Form will help us better serve our members. **This form is confidential**.

The SNF WQIP Provider Grievance process is established in accordance with applicable state and federal requirements, including the California Department of Health Care Services (DHCS) All Plan Letter 25-002, which requires managed care plans to maintain a formal procedure to accept, acknowledge, and resolve network provider grievances related to SNF WQIP payments, data, and related issues.

Instructions

1. Complete all applicable sections of this form.
2. Attach all supporting documentation relevant to your grievance (e.g., remittance advice, correspondence, claims, data reports).
3. Email the completed form and attachments to Carleton Booker, Alliance Long-Term Services and Supports (LTSS) Liaison, at **cbooker@alamedaalliance.org**.

   If the form and/or attachments include protected health information (PHI), please send a secure email. If you need help with this, please contact the LTSS Liaison.

Please Note:

- You will receive an acknowledgment of your grievance within three (3) business days of receipt.
- The plan will work with you to resolve the grievance and may request additional information as needed.
- Retain all correspondence and documentation related to your grievance for your records.

Section 1: Provider Information

Last Name: _____ First Name: _____

National Provider Identifier (NPI): _____ Tax ID Number (TIN): _____

Facility Name (if different): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Person Information

Full Name: _____

Phone Number: _____ Email Address: _____

Section 2: Grievance Type

Please select all that apply:

☐ Processing of SNF WQIP directed payments

☐ Non-payment of SNF WQIP directed payments

☐ Calculation of SNF WQIP qualifying bed days

☐ Other (please specify): _____

Section 3: Grievance Description

Provide a clear and concise description of the grievance, including the specific issue, relevant dates, and any actions taken to resolve the issue to date. Attach additional pages if necessary.

Section 4: Supporting Documents

List all documents attached to support your grievance (e.g., remittance advice, correspondence, claims, data reports):

1. _____
2. _____
3. _____

Section 5: Resolution Requested

Describe the action or resolution you are seeking (e.g., payment of a specific amount, correction of data):

Section 6: Provider Attestation

I attest that the information provided in this request is accurate and complete to the best of my knowledge.

Full Name (Print): _____

Title: _____

Provider/Authorized Representative Signature: _____ Date: _____

For Health Plan/Managed Care Organization Use Only

Date Received: _____ Date Acknowledgement Sent: _____

Case/Reference Number: _____

Notes/Comments: