New Mexico Medical Society
PROBLEM RESOLUTION REPORTING PROGRAM
Issues Reporting Form

Name of Physician: _____ Date: _____

Street Address: _____ City: _____ Zip Code: _____

Office Phone Number: _____ E-Mail Address: _____

Please address each problem separately. Be as specific as possible. If you have a recommended solution, please state it.

If more space is needed, please attach separate sheet of paper.

SALUD!_____ **COMMERCIAL _____**

ISSUE #1

Problem pertains to:

____ BC/BS
____ Lovelace Health Plan
____ Molina Healthcare
____ Presbyterian
____ United Healthcare
____ Other (Specify): _____

_____ Paper Claim **_____ Electronic Claim (NMMS preferred)**

Discussed with MCO? ____ Yes (If yes, to whom:_____) ____ No ____ N/A

Description of problem:

Suggested resolution:

- OVER -

Please address each problem separately. Be as specific as possible. If you have a recommended solution, please state it.

If more space is needed, please attach separate sheet of paper.

SALUD!_____ **COMMERICAL _____**

ISSUE #2

Problem pertains to: ____ BC/BS ____ Presbyterian
____ Lovelace Health Plan ____ United Healthcare
____ Molina Healthcare ____ Other (Specify):
_____

_____ **Paper Claim** _____ **Electronic Claim (NMMS preferred)**

Discussed with MCO? ____ Yes (If yes, to whom:_____) ____ No ____
N/A

Description of problem:

Suggested resolution:

MAIL TO:

New Mexico Medical Society
Problem Resolution Program
7770 Jefferson NE, Suite 400

Albuquerque, NM 87109