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