

Payment Dispute Decision (PDD) Request Form

Fill out all sections as required. Missing or incomplete information may result in your request being dismissed as invalid.
This form is to be submitted to C2C **after** the MAO's provider payment dispute process has been followed.

Provider Contact Information

Provider Name: _____
Provider Correspondence Address:
Street _____
City _____ ST _____ Zip _____
Telephone number _____ Email _____ @ _____

Pricing Information

NPI number: _____ and CCN or OSCAR number for institutional providers: _____

ZIP Code where services were rendered: _____

Physician Specialty, if dispute is on a physician claim _____

Medicare Advantage Organization (MAO) name: _____

Plan name/number: _____

Provider is deemed; or Provider is non-contracted

Note: Contracted providers may not use this independent payment dispute resolution process

Reason for Payment Dispute – a description of the specific issue

(A separate attachment may be utilized if necessary)

The following information **MUST** be submitted with this form:

1. Copy of the provider's claim which was submitted to MAO with disputed portion identified
2. Copy of the MAO's original payment determination (remittance advice)
3. Copy of the MAO's payment dispute decision (redetermination)
4. Any supporting documentation and correspondence that support your position that the MAO's payment is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare on similar or identical services)
5. Appointment of Provider Representative Authorization Statement, if applicable

Requester's Information

Name: _____
Title and Company name: _____
Street Address _____ City _____ ST _____ ZIP _____
Relationship to Provider _____
Telephone number _____ Email _____ @ _____
Requester's Signature: _____ **Date Signed:** _____

For electronic submissions only, in lieu of a signature:

By checking this box, I certify that I have proper authorization to submit this payment dispute on behalf of this provider.

Independence Blue Cross
Non Contracting Provider Appeals Department
P.O. Box 13652, Philadelphia, PA 19101-3652
Fax (215) 988-2001