



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: _____ | State: _____ | 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: _____ |
| <i>Note: Contracted providers may not use this independent payment dispute resolution process</i> |

| 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: _____ | |
| State: _____ | Zip: _____ | |
| Relationship to Provider: _____ | | |
| Telephone number: _____ | Email: _____ | |
| Requester's Signature: _____ | Date Signed: _____ | |

| FOR ELECTRONIC SUBMISSIONS ONLY, IN LIEU OF A SIGNATURE: |
|--|
| <input type="checkbox"/> By checking this box, I certify that I have proper authorization to submit this payment dispute on behalf of this provider. |