



PFFS 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.

Provider/Supplier Contact Information

Provider/Supplier Name: _____

Provider/Supplier Correspondence Address: _____

Street _____

City _____ ST _____ Zip _____

Telephone number _____ Email _____@_____

Pricing Information

NPI number (and CCN or OSCAR number for institution): _____

ZIP Code where services were rendered: _____

Physician Specialty, if dispute is on a physician claim _____

Medicare Advantage Organization (MAO) name: _____

PFFS Plan name/number: _____

Provider/Supplier is ___ deemed; or Provider/Supplier is ___ non-contracted

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/supplier's submitted claim with disputed portion identified
2. Copy of the PFFS plan's original payment determination
3. Copy of the PFFS plan's redetermination (dispute) payment decision
4. Copy of the relevant portion of Terms and Conditions or contract and any supporting documentation and correspondence that support your position that the plan'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.