Post Claims Adjudication Payment Dispute Form

CareFirst Community Health Plan Maryland

INSTRUCTIONS

Please use this form when submitting payment disputes, reconsiderations, and resubmissions within 180 calendar days from the date of service. One dispute request per form. Multiple claims can be attached with the same dispute reason. Do not use this form for pre-service and post-service appeals.

Definitions:

- **Claim Dispute:** A request from a health care provider for a post-service review of claims that have been denied or underpaid.
- **Reconsideration:** A request from a health care provider to CareFirst Community Health Plan to consider again its decision based on new or additional information submitted by the health care provider.
- **Resubmission:** A request for review of a claim denial or payment amount on a claim originally denied because of incorrect coding or missing information.

Please complete each section to process the request.

SECTION 1: CHECK THE REASON FOR THE REQUEST

	Authorization: ■ Claim denied for an authorization, however, approved authorization for date of service on file; include authorization # ____ ■ Claim denied for authorization, however, authorization is not required
	Code or Modifier Issue: Resubmitting claim with correct code or modifier
	Contract Rate: Claim was not processed based on contractual rate; includes single case agreements
	Coordination of Benefit (COB): Copy of primary insurer's explanation of benefit required
	Duplicate Claim: Originally denied as a duplicate claim; however, submitted documentation (e.g., medical record) shows two services were performed
	Invoice Attached: Claim originally denied for lack of invoice
	Itemized Bill: Claim originally denied for an itemized bill
	Paid to Wrong Provider: Claim paid to the wrong provider
	Other: ____

SECTION 2: REQUESTOR'S INFORMATION

Dispute Submission Date:	
First/Last Name:	Phone Number:
Email:	Fax Number:
Address:	City/State/Zip:

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SECTION 3: PROVIDER/CLAIM/MEMBER INFORMATION	
Name of Provider:	Billing NPI:
Rendering NPI:	Address:
City/State/ZIP:	Phone Number:
Claim Number(s):	Date(s) of Service:
Remittance Advice Date:	Billed Amount:
Contracted Amount:	Paid Amount:
Name of Member:	Member’s ID:
Member’s Date of Birth:	

SECTION 4: SUPPORTING DOCUMENTATION	
	Authorization number/letter or evidence that authorization is not required
	A copy of the primary insurance EOB
	Resubmitted claim with correct code or modifier
	Evidence of contracted rate or copy of fully executed **(signed by CareFirst CHPMD and provider)** single case agreement
	Medical records demonstrating two services were performed
	A clear copy of the manufacturer’s invoice, for service, device, or drug ▪ Services rendered must match the claim ▪ For drugs, the invoice to clearly show the per-unit cost of the drug and the NDC/Description must match the claim submission
	Attached itemized bill
	Evidence that the wrong provider was paid
	Other:

Submit this form and supporting documentation to:

CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD)
Claims Department
P.O. Box 915
Owings Mills, MD 21117

CareFirst CHPMD will respond to your request via EOP within 30 calendar days from receipt of the dispute and supporting documentation.