



Non-Contracted Provider Payment Dispute Form
 (APPLIES ONLY FOR DISPUTES DUE TO UNDER MEDICARE FEE PAYMENT OR DOWNCODE)

(Please read instructions below)

MMM of Florida
 Appeals & Grievances Department
 5775 Blue Lagoon Drive,
 Suite 450
 Miami, FL 33126

PROVIDER INFORMATION

Physician Facility Medicare ID:

Provider Name _____ Contact _____
 Rendering Provider NPI _____ Telephone _____
 Billing Provider NPI _____ Fax Number _____

MEMBER NAME	MEMBER ID	CLAIM NUMBER	CPT/HCPCs	DATE OF SERVICE	PRIOR PAYMENT	ESTIMATED AMOUNT DUE

Reason(s) for dispute:

INSTRUCTIONS

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

1. Form 1500/UB04
2. Copy of Explanation of Payment
3. Provider Contact information including name and address
3. Pricing Information, including NPI number (and CCN / OSCAR number for institutional providers), ZIP Code where services were rendered, Physician Specialty.
4. If available: Any supporting documentation and correspondence that support your position that the payment is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare on similar or identical services)
5. Copy of the provider's submitted claim with disputed portion identified

Choose one of the methods below to submit your Dispute request:

Mail to: Appeals and Grievances Department
 P. O. Box 260430
 Miami, FL 33126

Fax to: 1-833-523-2628

Important information:
 The time frame for disputing a reimbursement issue to the MAO Plan is 120 days from the initial determination date.
 Requests that do not contain all required elements are considered incomplete and subject to dismissal. Waiver of liability is not a requirement for the Dispute process.
 Every dispute is processed within 30 days from the receipt date.
 If you have any question, please contact the Provider Relations Department at 1-(844) 212-9858 from Monday to Friday 8:00 AM - 5:00 PM

PROVIDER SIGNATURE _____ DATE: _____