MMM
Medicare and Much More

Waiver of Liability

Dear Provider:

On _____, we received an appeal requesting the revision of our payment determination. However, it was identified that you are not contracted by MMM; the Centers for Medicare and Medicaid Services (CMS) requires us that you complete the enclosed waiver of liability in order for us to be able to work your appeal.

Member's name: _____
Member's ID: _____
Date of Service: _____

We will have 60 calendar days to work your appeal once the signed waiver of liability is received at the plan. If we do not received this document the appeal will not be analyzed and will be closed.

If you need additional information, please feel free to contact our Provider Services Department at 1- (844) 212-9858 (toll free) from Monday through Friday from 8:00 a.m. to 8:00 p.m.

*** You can send back us the Signed Waiver of Liability by our direct Fax: 1-833-523-2628.**

Sincerely,

Appeals and Grievances Department

Enclosed: Waiver of Liability

PO BOX 260430 MIAMI, FL 33126

Medicare and Much More

Waiver of Liability Statement

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

_____
Health Plan

In order to comply with CMS, Center of Medicare and Medicaid Services, we appreciate if you read, sign and send this letter within 30 calendar days to the Appeals and Grievances Department. We will evaluate your case within the next 60 calendar days once this letter is received. Please read carefully the following paragraph.

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by MMM Healthcare, LLC. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

_____ _____
Signature *Date*

Source: CMS Medicare Managed Care Manual Chapter 13 Appendix 7- Waiver of Liability Statement (Rev.105, Issued: 04-20-2012, Effective Date: 04-20-12; Implementation Date: 04-20-2012)

PO BOX 260430 MIAMI, FL 33126

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:**_____

Claim Adjustment Form

Provider Information

A. ☐ **Part-Provider** ☐ **Non-Part Provider**

B. ☐ Physician
☐ Facility ☐ Other: _____

C. **Type of Adjustment**
☐ Annual Form (AHA)
☐ Claim Adjustment ☐ Other: _____

D. Provider Name: _____

Tax ID: | | | | | | | | | | | Phone _____

Rendering NPI : | | | | | | | | | | | Email: _____

Billing NPI: | | | | | | | | | | |

Member Name	Member Plan ID	Plan Claim ID	Date of Service	Payment or Denied Date	Reason	Comments

Adjustment Reason

1 Co-Pay does not Applies **3** Unit Differences **5** Incorrect Provider **7** POS Correction

2 Insufficient payment **4** Incorrect Dx **6** Proveedor con cuota incorrecta **8** Other: _____

Additional Comments: _____

Important Instructions

1. Please include a copy of the claim or explanation of payments (EOP)

2. Send us corrected UB_04 or HCFA1500 Form

3. Please include any support documentation for this adjustment request

Send to:
MMM of Florida, Inc.
ATTN: CLAIMS Adjustments Request
PO Box 71305
San Juan, PR 00936-8405

Requestor Name **Requestor Signature** **Date:**