PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

Billing Dispute Resolution Request Form

Fields with a red asterisk (*) are required

Provider Information

Date Submitted (MM/DD/YYYY) *

___ / ___ / ___

Note: All requests must pertain to a claim with dates of service that are within the timely filing guidelines. If the billing dispute pertains to a claim that is already past the timely filing limit, no action will be taken.

Provider Name *

Provider Number *

NPI *

TIN *

Contact Person/Name *

Contact Phone Number & Extension *

(___) ___ - ___ x ___

Patient/Beneficiary Information

First Name *

Last Name *

Medicare Beneficiary Identifier (MBI/HIC) *

Date of Birth (MM/DD/YYYY) *

___ / ___ / ___

Claim Information

Note: A separate form must be completed for each patient/beneficiary.

Date(s) of Service (Enter all that apply. MM/DD/YYYY) *

From: ___ / ___ / ___ Through: ___ / ___ / ___

DCN(s) (Enter all that apply) *

Contact Resolution Information

Note: The following information is required to establish the provider's attempt to resolve the billing dispute prior to contacting Palmetto GBA for assistance.

Name of Agency Contacted *

Name of Individual Contacted *

Date Agency was Contacted (MM/DD/YYYY) *

___ / ___ / ___

Is the agency out of business? *

Yes No

Method of Contact (select one) *

Phone Fax Letter Other

If "Yes," please explain.

Identify the Situation (Check one) *

Billing Overlap (This applies to instances where two providers are billing for overlapping dates of service, which may include a transfer situation.)

If Billing Overlap, please include the following information with your inquiry:

- Records of Admission and Discharge of patient stay
- Signed Patient Transfer Form (If overlap exist). For hospice agencies, a transfer form from both hospice agencies must be included.
- Point of Contact made to overlapping facility (Must have at least three contacts made, must include an internal communication log with records)
- Email, Phone, Fax or Mail acceptable (One of the three attempts must be written communication. Documentation of email or mail must be included in records)

Sequential Billing (This applies to instances where one provider has billed before another agency has completed their billing.)

Additional Comments

Note: If you need more space, put "See Attached" in the box below and submit your comments on a separate sheet with your inquiry.

Please send this form and all additional documentation to

Fax: (803) 462-2215

Palmetto GBA
Attn. Provider Contact Center AG-840
P.O. Box 100238
Columbia, SC 29202-3238

PC-JM-A-3000

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