TRIPLE-S ADVANTAGE
Blue Cross Blue Shield of Puerto Rico

Non-Contracted Provider Payment Dispute Form

(APPLIES ONLY FOR DISPUTES DUE TO UNDER MEDICARE FEE PAYMENT OR DOWNCODE)
(Please read instructions below)

Triple S Advantage
PO Box 11320
San Juan, PR 00922

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 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
4. Pricing information, including NPI number (and CCS/OSACR number for institutional providers), ZIP code where services were rendered, Physician Specialty.
5. 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)
6. Copy of the provider's submitted claims with disputed portion identified

Choose one of the methods below to submit your Dispute request:
Mail to:
Claims Department
Re: Provider Payment Dispute
PO Box 11320
San Juan PR 00922

Important information:
The time frame for disputing a reimbursement issue to the MAO Plan is 120 days from the initial determination date.
Request that do not contain all required elements are considered incomplete and subject to dismissal. Waiver of liability is 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 787-620-1919 ext. 4171 or 1-888- 620-1919 (toll free) from Monday to Friday 8:00am to 5:00pm

PROVIDER SIGNATURE _____ **DATE** _____