

## SECTION 1011 DISPUTE RESOLUTION REQUEST

**DIRECTIONS:** If you wish to request a dispute resolution on a payment request determination, please fill out this form and mail it, along with documentation, to:

Highmark Medicare Services  
Attn: Section 1011  
P.O. Box 890121  
Camp Hill, PA 17089-0121

**NOTE:** Failure to complete **ALL** the data elements on this form **and/or** failure to submit the necessary documentation will result in your request for a dispute resolution being dismissed. Disputes must be submitted no later than 45 days after the quarterly payment date for the quarter in which the disputed payment request was billed.

PROVIDER NAME

SECTION 1011 PROVIDER IDENTIFICATION NUMBER (PIN)

PATIENT IDENTIFIER NUMBER (HIC)

DOCUMENT CONTROL NUMBER (DCN)

FULL DATE RANGE OF SERVICE

SPECIFIC DATE(S) OF ITEMS IN DISPUTE

ORIGINAL AMOUNT SUBMITTED FOR REIMBURSEMENT

DENIED SERVICE AND REASON FOR DISPUTE

REQUESTER'S NAME

TITLE

REQUESTER'S E-MAIL ADDRESS

REQUESTER'S MAILING ADDRESS

CITY

STATE

ZIP CODE

REQUESTER'S TELEPHONE NUMBER (INCLUDE AREA CODE)

REQUESTER'S SIGNATURE

DATE SIGNED

- All documentation regarding dispute is attached.
- Letter of representation is attached (if requester is an entity other than the provider).

Please note that Highmark Medicare Services will not send an acknowledgment of receipt and providers may not appeal finalized disputes. Highmark Medicare Services will notify providers of decisions via e-mail.