





## Highmark Blue Shield Billing Dispute Form For MDs and DOs

**Request for Physician Billing Dispute External Review:**

<b>Date of Service:</b> 	<b>Claim Number (Indicated on Explanation of Payment):</b> 
<b>Amount In Dispute:</b> (the additional amount you believe you are entitled to receive in this dispute):  \$	<b>Filing Fee:</b> (Please check one.)  <input type="checkbox"/> \$50.00 Disputed amount greater than \$500 and less than or equal to \$1000.  <input type="checkbox"/> \$50.00 + 5% of amount of dispute which exceeds \$1000. The fee may not exceed \$75.  <input type="checkbox"/> No amount is enclosed because this claim is an aggregate of a deferred claim for which a filing fee has previously been paid.
<b>Amount Enclosed: \$</b>  Please make check payable to <b>IMEDECS</b> .	

The decision of IMEDECS is final and binding on Highmark Blue Shield and the physician or physician group only with respect to the specific case under review by IMEDECS.

For more information on the BDERB process, you may access the Highmark Blue Shield Office Manual under Administrative Reference Materials on the Provider Resource Center or visit the IMEDECS website ([www.IMEDECS.com](http://www.IMEDECS.com)).

**Comments:**

I hereby acknowledge and agree to be bound by the terms of the Billing Dispute External Review Process including the attached instructions, further certify that I am a class member of the Love Settlement Agreement, and further certify the accuracy of the material and information submitted with the request.

**Signature of Physician:**

**Print Name:**

**Date:**