BlueCross BlueShield Nebraska

Out of Network Emergency Medical Care Act - Reimbursement Dispute Request

Form must be completed within 60 days of remittance, or it will not be processed

THIS FORM IS ONLY APPLICABLE IF A CLAIM HAS BEEN PROCESSED AND A REMITTANCE ADVICE HAS BEEN ISSUED BY BLUE CROSS AND BLUE SHIELD OF NEBRASKA (BCBSNE).

Member's Name: _____ Patient's Name: _____

Member's ID Number: _____ Relationship to Member/Primary Cardholder: _____

BCBSNE Claim Number: _____ Date(s) of Service: _____

Provider Name: _____ Location of Services _____

Individual NPI: _____ Clinic Tax ID or NPI: _____

Contact Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

Reimbursement Dispute: Notice to BCBSNE that the payment made has been deemed unreasonable by the out-of-network health care provider.

Any payment issued *must* be returned with this form, or this request will not be processed. In accordance with LB997, the dispute process will begin as of the date of receipt of this form by BCBSNE. Until resolved, covered persons cannot be balance billed for amounts over the allowable amount.

PLEASE DESCRIBE IN DETAIL WHY YOU ARE DISPUTING THE REIMBURSEMENT. VAGUE OR INCOMPLETE RESPONSES WILL DELAY OR POSSIBLY CAUSE A DENIAL OF YOUR REQUEST.

Comments:

NOTE: The insurer and health care provider shall have 30 days after the date of notification to negotiate a settlement. If a settlement has not been reached after such 30-day period, the insurer and health care provider shall engage in mediation in accordance with the Uniform Mediation Act. Following mediation, the cost of mediation shall be paid by and split evenly between the insurer and health care provider.

Please submit reimbursement dispute form to:
Blue Cross and Blue Shield of Nebraska
Attention: HNS - Provider Contracting
PO Box 3248
Omaha NE 68180-0001

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