

# BCBSAZ Claim Payment Negotiation Request Form



An Independent Licensee of the Blue Cross Blue Shield Association

For non-participating providers to initiate the negotiation process under the No Surprises Act, to dispute an initial claim payment

Non-participating providers may dispute the initial amount paid on a claim for emergency, air ambulance, or other professional services that are in scope for the No Surprises Act (NSA). To initiate the 30-day negotiation process provided under the NSA, complete and send this form to Blue Cross® Blue Shield® of Arizona (BCBSAZ), along with a copy of the remittance advice. The 30-day negotiation period starts when we receive a fully completed request form and remit statement. Any dispute that is not settled within the 30-day period may be referred to an independent federal arbitrator.

<b>CONTACT PERSON</b>	Name of contact person for this request	
	Phone	Email
<b>SCHEDULING AVAILABILITY</b> (for virtual negotiation meeting)	Scheduling option 1	Scheduling option 2

<b>REQUESTING ENTITY</b>	Name of provider, group, or facility requesting this review	
<b>REASON FOR REQUEST</b>	Explain the reasons why you are disputing the initial payment amount. If available, list the evidence or sources of information that you wish to offer in support of your position.	
<b>REQUIRED INFORMATION</b>	The information below is required to process your request	
1. Claim ID	Claim number	
	Date of service	
	Provider name	
	Provider NPI	
	Provider tax ID	
	Member name	
	Member ID	
	Member date of birth	
	Claim process date	
2. Claim Financial Data	Billed amount	
	Initial BCBSAZ payment amount	
	Patient responsibility amount	
	Additional payment requested	

**Attestation and Authorized Electronic Signature**

I am (name, title) \_\_\_\_\_  
and I am authorized to submit this request. By entering my name in the electronic signature box below, I attest that the information on this form is accurate and complete to the best of my knowledge, information, and belief.

/s/ \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Authorized Electronic Signature Date (mm/dd/yyyy)

Email your completed request form (all fields required) and a copy of the remit to [NSArequest@azblue.com](mailto:NSArequest@azblue.com).