# Medicare provider appeal process for non-contracted providers

## Medicare Advantage Organization

### Filing a request for review of a denied claim

In accordance with the Centers for Medicare & Medicaid Services (CMS) regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration of a Medicare Advantage plan denial of payment. Requests for reconsideration of a denied claim must be submitted within 60 days of the date of the remittance advice and a signed waiver of liability (WOL) statement is required by CMS. The form can be found in the Claims Resources and Guides section of www.ibx.com/providers.

Requests for reconsideration of a denied claim must be submitted in writing and should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's disagreement for reimbursement. Once we receive the completed form, we will review the request and provide a decision on your appeal within 60 calendar days.

You may mail your written appeal to:

Independence Blue Cross
Medicare Member Appeals Department
P.O. Box 13652
Philadelphia, PA 19101-3652