



# REQUEST FOR A PAPER REMITTANCE COPY

## *Non-participating providers and dentists*

Please return this completed form to:  
 Blue Cross Blue Shield of Massachusetts  
 Electronic/Paper Intake Team  
 PO Box 986065  
 Boston, MA 02298

This form can only be used by non-participating providers and dentists to request a duplicate paper copy of a Provider Detail Advisory (PDA) or a Provider Payment Advisory (PPA). All other providers are required to get an electronic copy of a PDA or PPA using PaySpan at [payspanhealth.com](https://payspanhealth.com) (registration is required).

Today's date: \_\_\_\_\_

REQUESTER'S INFORMATION			
Name and job position:			
Phone number:		Fax number:	
Email address:			

BILLING PROVIDER'S INFORMATION				
Provider name:			Billing NPI:	

MEMBER'S INFORMATION				
Member name:			Date of service:	
Member ID (including prefix):			Billing amount:	
Claim number:				

REASON FOR REQUEST (PLEASE CHECK ONE)	
<input type="checkbox"/> Never received <input type="checkbox"/> Request for 3 <sup>rd</sup> party submission <input type="checkbox"/> Duplicate <input type="checkbox"/> Other: _____	

## OUR RESPONSE TO YOUR REQUEST

If your request is:	Then:
<input type="checkbox"/> Approved	A copy will be mailed to the provider site address listed on our provider file within 14 days.
<input type="checkbox"/> Denied	You will need to contact Network Management and Credentialing Services at <b>1-800-316-2583</b> for information on how to submit an address change. (The site address you provided is different from what we have on our provider file). You may receive a letter from us if we cannot complete your request.
<input type="checkbox"/> Incomplete	The form will be returned to you for completion.

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