Provider BlueCard Claim Appeal Form

**Denotes required field*

*Today's Date (MM/DD/YY):	
PROVIDER INFORMATION	
*Provider Name	*Contact Name
*NPI	*Contact Phone Number
Contact Email	Contact Fax Number
*Contact Address	
MEMBER/CLAIM INFORMATION	
*Member Name	*Claim Number
*Member ID (including prefix)	*Denial Code(s)
*Date(s) of Service (MM/DD/YY)	

TYPE OF APPEAL*

(CHECK ONE OF THE FOLLOWING REASONS FOR DENIAL OR CLAIMED UNDERPAYMENT, AND ATTACH ALL SUPPORTING DOCUMENTATION, INCLUDING ANY NECESSARY MEMBER AUTHORIZATION)

	Contract Term(s): Original claim was not paid or processed in accordance with contract terms.
	Coordination of Benefits: Original claim denied or closed pending receipt of additional information from another insurer or other reason related to COB.
	Corrected Claim: Previously processed claim was denied for a defect and/or error and requires a correction. Please specify the correction to be made:_____
	Duplicate Claim: Original claim denied as duplicate to a previously finalized claim.
	Timely Filing: Original claim denied for untimely filing (and proof of timely filing is attached).
	Precertification/notification or Prior-Authorization: Original claim denied or Provider received reduced payment for failure to notify or pre-authorize services or exceeding authorized limits (and proof of valid notification/authorization is attached).
	Medical Necessity: Original claim denied as a result of medical necessity/utilization review decision.
	Referral Denial: Original claim denied as invalid or missing a required referral.
	Request for Additional Information: Original claim denied due to missing or incomplete information (and missing information or identification of such information in previously-submitted records is attached).
	Other Type of Denial/Claimed Underpayment:

Brief Explanation:

FOR PROVIDER USE ONLY

INCOMPLETE OR DISALLOWED SUBMISSIONS WILL BE RETURNED

NOTHING IN THIS FORM CREATES A RIGHT TO APPEAL WHERE NONE EXISTS UNDER AN APPLICABLE AGREEMENT OR LAW