BlueCross BlueShield of Texas

Provider Appeal Request Form

- Please complete one form per member to request an appeal of an adjudicated/paid claim.
- Fields with an asterisk (*) are required.
- Be specific when completing the "Description of Appeal" and "Expected Outcome."
- Please provider all **supporting documents** with submitted appeal.
- Appeals received **incomplete appeals form or missing documents will be returned for your completion**
- Appeals must be submitted within 120 days of the remittance date.
- Mail or Fax the completed form to:

Blue Cross and Blue Shield of Texas
Attn: Complaint and Appeal Department
P.O. Box 660717
Dallas, Texas 75266
Fax: (855) 235-1055

Line of Business Type*:(Check One): ☐ CHIP ☐ STAR ☐ STAR Kids

Provider Name*: _____

National Provider Identifier (NPI) Number:_____ Texas Provider Identifier (TPI) Number: _____

Tax ID Number: _____

Street Address*: _____

City*:_____ State*:_____ ZIP code*: _____

Provider Type: ☐ PCP - Primary Care Physician ☐ ASC -Ambulatory Surgery Center ☐ Specialist ☐ Hospital
☐ DME -Durable Medical Equipment ☐ SNF- Skilled Nursing Facility ☐ OBGYN
☐ FQHC/RHC ☐ Behavioral Health

☐ Other (please specify): _____

CLAIM INFORMATION

Member Name*:_____ Date of Birth: _____

Subscriber ID Number or Medicaid ID*:_____

Original Claim ID Number(s)/Corrected Claim ID Number(s): _____

Service "From/To" Dates* (dates of services):_____/_____

Original Claim Amount Billed:_____ Original Claim Amount Paid: _____

Appeal Reason*: ☐ Eligibility ☐ Coordination of Benefits ☐ Authorization ☐ Claim Payment Incorrectly ☐ Timely Filing
☐ Medical Necessity ☐ Other

_____

_____

_____

_____

Expected Outcome*: _____

Contact Name (please print)*:_____ Title:_____

Phone Number*:_____ Fax Number: _____

Signature:_____ Date: _____

☐ Check here if medical records are attached. ☐ Check here if additional information is attached.

For Health Plan Use Only Appeal Number:_____

Provider appeals acknowledgement receipt will be sent to organization first (5) days and resolved within (30) days of receipt.

- This is not a claims reconsideration form. Please use the claims reconsideration located at www.bcbstx.com/provider/medicaid/