



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/