Provider Appeal Request Form

Submission of this form constitutes agreement not to bill the patient during the Appeal process.

- 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."
- Provide additional information to support the description of the Appeal.
- 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

Plan Type*: (Check One): CHIP ☐ STAR ☐ STAR Kids ☐

Provider Name*: _____

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

Rendering Provider NPI Number: _____ Tax ID Number: _____

Street Address*: _____

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

Provider Type: ☐ PCP ☐ Specialist ☐ Hospital ☐ FQHC/RHC ☐ ASC ☐ Behavioral Health ☐ Long Term Services Support ☐ Skilled Nursing Facility

☐ Other (please specify): _____

CLAIM INFORMATION

Patient Name*: _____ Date of Birth: _____

Health Plan ID Number or Medicaid ID*: _____ Patient Account Number: _____

Original Claim ID Number: _____

Service "From/To" Dates* (required for claim, billing, and reimbursement of overpayment appeals): _____ / _____

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

Appeal Reason*: ☐ Eligibility ☐ Coordination of Benefits ☐ Authorization ☐ Claim Paid Incorrectly ☐ Timely Filing ☐ 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 Tracking Number: _____ Provider ID #: _____

www.bcbstx.com/provider/medicaid/