

Provider Appeal Form

Please complete the following information and return this form with supporting documentation to the applicable address listed on the corresponding appeal instructions. Send only one appeal form per claim. Appeals must be submitted within one year from the date on the remittance advice. **Appeal Type and Sub Category must be checked to ensure proper routing.**

Date

Clinical Appeal Type (check one)

<input type="checkbox"/> Utilization Management (see below)	<input type="checkbox"/> Adverse Determination (Medical Necessity or Experimental/ Investigational)	<input type="checkbox"/> Coding and Payment Rule
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If a Utilization Management Appeal, complete the following:

Type: <input type="checkbox"/> Authorization <input type="checkbox"/> Precertification	Authorization or Precertification Number
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Administrative Appeal Type (check one)

<input type="checkbox"/> Claim Allowance	<input type="checkbox"/> Coordination of Benefits	<input type="checkbox"/> Provider Contract Issue	<input type="checkbox"/> Timely Filing	<input type="checkbox"/> Other	<input type="checkbox"/>
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If Administrative Appeal (Reconsideration Reference # Must Be Listed)

Reconsideration Reference #

1. Provider Information

Provider Name		NPI #	Florida Blue #	
Street Address		City	State	Zip 2
Tel. #	Fax #	Contact Name		

2. Patient Information

Patient Last Name	Patient First Name
Contract/ID # (alpha & #s)	Patient Date of Birth

3. Claim Information

Claim Number	
Billed Amount	Date(s) of Service (MM/DD/YYYY);(From) (To)
Procedure Code(s):	

4. Appeal Reason (Explain the reason for the appeal in the space below.)

Supporting Documentation

The following supporting documentation must be attached to this form:

- Copy of the remittance advice or member's explanation of benefits. Indicate the code(s) or service(s) being appealed.
- Medical documentation related to the appeal (medical records, operative report, inpatient or emergency room face sheet, etc.) See applicable instructions for your appeal type.
- Any additional documentation.