Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Mail to the address listed in the corresponding appeal instructions

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**)

☐ Utilization Management (see below)	☐ Adverse Determination (Medical Necessity or Experimental/ Investigational)	☐ Coding and Payment Rule

If a Utilization Management Appeal, complete the following:

Type: ☐ Authorization ☐ Precertification	Authorization or Precertification Number

Administrative Appeal Type (check one)

☐ Claim Allowance	☐ Coordination of Benefits	☐ Provider Contract Issue	☐ Timely Filing	☐ Other	☐

If Administrative Appeal (Reconsideration Reference # Must Be Listed)

Reconsideration Reference #

1. Provider Information

Provider Name		NPI #	Florida Blue #	
Street Address		City	State	Zip
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:

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