NON-CONTRACT PROVIDER POST SERVICE APPEAL FORM FOR BLUE MEDICARE HMO[SM] AND BLUE MEDICARE PPO[SM]

BlueCross BlueShield of North Carolina

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Section I: Patient Information

Alpha Prefix (Copy from the member's BCBSNC identification card)

Patient Date of Birth - -

Subscriber Number **(Copy from the member's BCBSNC identification card)**

Patient Name (First, middle initial, last)

Section II: Physician Information

Requesting Physician (Print first, last name)

Requesting Physicians Signature (Signature & date)

Fax - -

Phone - -

Physician NPI Number

Physician Mailing Address (Street or P.O. Box, City, State & Zip Code)

Section III: Appeal Information

Date of Service - -

EOP Date of Notification of Denial - -

CPT Codes -

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Diagnosis Codes .

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Claim Identification Number

APPEAL REASON (Please state reason for appealing and attach any additional information you believe may help your case): If additional space is needed, please use the back of this form.

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This form is intended for use only when a non-contract provider is requesting a review of a service that has been provided to a BCBSNC Medicare Advantage member and denied. Completed forms, must include the **Waiver of Liability form,** and any supporting documentation (a copy of the original claim, denial notice, and/or any clinical records), and should be sent to**:** ***Blue Medicare HMO[SM] and Blue Medicare PPO[SM], Attn: Non Contract Appeals and Grievances, P.O. Box 17509, Winston-Salem, NC 27116-7509.***
Please refer to the Blue Medicare HMO[SM] and Blue Medicare PPO[SM] Non- Contract provider section located on the BCBSNC Web site for providers at www.bcbsnc.com/providers/