

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.

Date _____

Appeal Type (check one)

<input type="checkbox"/> Utilization Management (see below)	<input type="checkbox"/> Adverse Determination	<input type="checkbox"/> Coding and Payment Rule	<input type="checkbox"/> Other
--	--	--	--------------------------------

If a Utilization Management appeal, complete the following:

Type: <input type="checkbox"/> Authorization <input type="checkbox"/> Precertification	Authorization or Precertification Number
--	--

1. Provider Information

Provider Name		Provider Number		
Street Address		City	State	Zip
Telephone Number ()	Fax Number ()	Contact Name		

2. Patient Information

Patient Last Name	Patient First Name
Contract/ID Number (alpha prefix and numbers)	Patient Date of Birth
Subscriber Last Name	Subscriber First Name

3. Claim Information

Claim Number	Product (e.g., BlueCare, BlueOptions, etc.)
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.

Provider Appeal Instructions

Physicians and providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as appeals.

There are four different types of appeals. Please review the instructions for each below to ensure proper routing of your appeal.

Utilization Management Appeals

The appeal must relate to an authorization or precertification problem that affected a claim payment.

Note: If your authorization was denied, please follow the instructions below for Adverse Determination Appeals (Medical Necessity or Experimental/Investigation).

Step 1. Check the "Utilization Management" box under Appeal Type; check the appropriate box for the Utilization Management appeal reason, either "Authorization" or "Precertification"; and enter the authorization or precertification number. Complete sections 1-4. Please describe the authorization or precertification issue that affected your claim's payment in as much detail as possible. If necessary, use additional sheets. Supporting documentation must be submitted.

Step 2. Mail the form and supporting documentation to:

Blue Cross and Blue Shield of Florida
Provider Disputes Department
P.O. Box 43237
Jacksonville, FL 32203-3237

This address is intended for Provider UM Claim Appeals only. Any other requests will be directed to the appropriate location, which may result in a delay in processing your request.

Adverse Determination Appeals (Medical Necessity or Experimental/Investigational)

The appeal must relate to a post-service claim denial made by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) that certain services provided to BCBSF's members by providers are not covered services because they are not Medically Necessary or Experimental or Investigational in nature.

For the definition of medical necessity, refer to Physician Disclosures at www.bcbsfl.com, under Physicians & Providers.

Step 1. Check the "Adverse Determination" box under Appeal Type. Complete sections 1-4. Please describe the issue in as much detail as possible. If necessary, use additional sheets. Supporting documentation must be submitted.

Step 2. Mail the form and supporting documentation to:

Blue Cross and Blue Shield of Florida
Provider Disputes Department
P.O. Box 44232
Jacksonville, FL 32231-4232

Coding and Payment Rule Appeals

The appeal must relate to the BCBSF or Health Options, Inc. application of coding and payment rules, and methodologies for professional service claims (including without limitation any bundling, downcoding, application of a CPT[®] modifier, and/or other reassignment of a code by BCBSF) in connection with health care services rendered to a specific individual covered under a policy or plan insured or administered by BCBSF or Health Options, such as:

- Procedure bundling
- The appropriate amount of payment, as determined by BCBSF or Health Options, when two or more CPT codes are billed together. Such payment rules may include:

- Duplicate Procedures
 - Multiple Surgery Guidelines
 - Coordination of Benefits
 - Multiple Imaging Edits
 - Multiple Evaluation and Management Service Edits
- Whether a payment-enhancing modifier is appropriate. Such payment enhancing modifiers are:
 - Assistant Surgeons (includes modifiers 80, 81 and 82)
 - Modifier 22 Unusual Procedural Services
 - Modifier 23 Unusual Anesthesia
 - Modifier 24 Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period
 - Modifier 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
 - Modifier 57 Decision for Surgery
 - Modifier 59 Distinct Procedural Service
 - Modifier 62 Two Surgeons
 - Modifier 66 Surgical Team

Step 1. Check the “Coding and Payment Rule” box under Appeal Type. Complete sections 1-4. Please describe in as much detail as possible the coding, payment rule or modifier that is the subject of your appeal. If necessary, use additional sheets. Supporting documentation must be submitted.

Step 2. Mail the form and supporting documentation to:

Blue Cross and Blue Shield of Florida
 Provider Disputes Department
 P.O. Box 44232
 Jacksonville, FL 32231-4232

All Other Appeals

If an appeal does not fit into any of the three categories listed above, it is considered an appeal type of “Other.” Examples include but are not limited to:

- Out-of-network provider requesting additional payment without changing the claim’s original billing information.
- Claims denied as being outside the provider’s scope of service or contract
- Claims denied as services not payable under provider agreement
- Claims denied as services are not eligible for reimbursement

Step 1. Check the “Other” box under Appeal Type. Complete sections 1-4. Please describe the issue in as much detail as possible. If necessary, use additional sheets. Supporting documentation must be submitted.

Step 2. Mail the form and supporting documentation to:

Blue Cross and Blue Shield of Florida
 P.O. Box 1798
 Jacksonville, FL 32231