Appeal filing form

Date (mm/dd/yyyy)	Identification number	Subscriber name

Patient name	Patient date of birth (mm/dd/yyyy)

Patient address	Patient city, state, ZIP

Daytime phone (including area code)	Email	Can we contact you by email? Yes No

Name of person filing appeal (if other than patient)

If the person filing the appeal is someone other than the patient, the patient must complete the Designation of Authorized Appeal Representative Form which can be found at **skaibcbs.com/members/forms**.

Claim information

Date(s) of service	Claim number(s)

Provider name (list all that apply)

Briefly describe the reason for your appeal

Return mail, fax or email the responses to:
Skai Blue Cross Blue Shield
P.O. Box 50
Little Rock, AR 72203-0050
Fax: 501-379-1200

You may ask for an expedited pre-service appeal by clearly identifying the appeal as “urgent” and emailing to **urgentappeals@arkbluecross.com** or faxing to **501-379-1214**.

Please send your denial notice and any documentation supporting your appeal along with this completed form to the address above.

Contact Customer Service at **844-465-5227** if you have questions or need assistance.