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: 501-378-3399 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.