Claim Re-Review/Provider Appeal Cover Sheet – Provider Requests

Attach Explanation For Request And Supporting Documentation To Coversheet

INSTRUCTIONS: **Submit a separate form for each member**. This cover sheet is to be completed by physicians, hospitals, or other health care professionals to request a Claim Re-Review or appeal on members enrolled in Arkansas Blue Cross and Blue Shield, Octave Blue Cross and Blue Shield, or Health Advantage Plans. There are two stages available; 1) Claim Re-Review and 2) Provider Appeal. If you disagree with the processing of a claim, the **first step is the submission of a *Claim Re-Review***. If you disagree with the Claim Re-Review decision, you may then submit a *Provider Appeal*. **Do NOT use this form for submitting new or corrected claims, requesting timely filing exceptions, responding to bar code request letters for medical information, or submitting coordination of benefits information**. Please be sure to attach all pertinent information to support your request. If requesting a *Provider Appeal*, please be sure to include a copy of the determination response from the *Claim Re-Review*. All re-review and appeal requests must be submitted in writing within 180 days of the claim denial.

Request information

Line of Business (Select One):

- ☐ Arkansas Blue Cross
- ☐ Health Advantage
- ☐ Octave Blue Cross

Request Level (Select One):

- ☐ **Claim Re-Review Request**
- ☐ **Provider Appeal**

Reason For Request (**attach explanation for request and supporting documentation**):

- ☐ Pricing Issue
- ☐ Fragmented Charge Denial — Fragmented or "bundled claim" issue
- ☐ Resubmission of "Prior Notification Information"
- ☐ Other: _____

Provider information

Type of Provider:

- ☐ Physician
- ☐ Hospital
- ☐ Other health care professional (Lab, DME, etc.)

Date Form Completed: _____

NPI # or tax ID:	**Provider name (as listed on RA/EOB):**	
Facility/group name	**Contact person**	**Phone number**
Email	**Fax**	**Has a re-review already been completed?** ☐ Yes ☐ No

The determination will be sent to the contact information provided on the form.

If a Provider Appeal is submitted before a Claim Re-Review is completed, the Claim Re-Review option is waived.

Member information

Member ID#

Member's name	**Denial reason**	**CPT Code at issue**
Claim #	**Date of service**	**Billed amount**

Provider mailing instructions

Claim Re-Review

For **Arkansas Blue Cross** and **Octave Blue Cross**, mail request to:

> Arkansas Blue Cross and Blue Shield
> Attn: Medical Re-review
> PO Box 3688
> Little Rock, AR 72203-3688
> Fax: **501-378-2058**

Provider Appeal

For **Arkansas Blue Cross** and **Octave Blue Cross**, mail request to:

> Arkansas Blue Cross and Blue Shield
> Attn: Appeals Coordinator
> PO Box 2181
> Little Rock, AR 72203-2181
> Fax: **501-378-3366**

Claim Re-Review **and** *Provider Appeal*

For **Health Advantage**, mail request to:

> Health Advantage
> Attn: Member Response Coordinator
> PO Box 8069
> Little Rock, AR 72203-8069
> Fax: **501-212-8518**
> ASE PSE Health Advantage fax: **501-378-2916**

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Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
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Octave BlueCross BlueShield
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