

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 Federal Employee Program 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:

☐ Federal Employee Program

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.



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Member information

Member ID#

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

Provider mailing instructions

Provider Appeal

FEP Appeals
Attn: Appeals Coordinator
PO Box 2181
Little Rock, AR 72203-2181
Fax: **501-210-7042**
Email: fepmemberandproviderappeal@arkbluecross.com

Claim Re-Review

FEP
PO Box 2181
Little Rock, AR 72203-2181
Fax: **501-378-2469**
Email: Customerservicefep@arkbluecross.com

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