

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: 501-379-1250

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 **800-818-1263** if you have questions or need assistance.