



Please Choose One:

- Professional Facility
- Allied Health Other

INSTRUCTIONS

Please complete the following information and return this form with supporting documentation (including medical records). If the supporting documentation is not received, your claim will not be reconsidered. Please return this to the address printed at the bottom of this form along with a copy of the Blue Cross and Blue Shield of Louisiana card.

PROVIDER NAME			
BLUE CROSS PROVIDER NUMBER		NATIONAL PROVIDER IDENTIFIER (NPI)	
SUBSCRIBER NAME		PATIENT NAME	DATE(S) OF SERVICE
CONTRACT NUMBER	CLAIM NUMBER		AMOUNT CHARGED
PROVIDER CONTACT NAME		PROVIDER CONTACT NUMBER	
<p>*REASON FOR APPEAL (Attach Additional Explanation If Necessary)</p> <p><input type="checkbox"/> Disagree with medical code editing and/or disagree with denial - i.e. assistant surgeon</p> <p><input type="checkbox"/> Claim not paid according to fee schedule and/or reimbursement amount is incorrect</p>			

Please send any supporting documentation with this form.

Please submit a hard copy of all claim(s). The decision rendered will be reflected on the members Explanation of Benefits/Payment Register and/or reported to you via office correspondence, if necessary.

IF THESE SERVICES WERE RENDERED YOU MUST SUBMIT THE FOLLOWING INFORMATION:

<p>A) SURGERY, ASSISTANT SURGERY, ANESTHESIA</p> <p>1) Discharge Summary 2) Operative Report 3) Pathology Report 4) Anesthesia Report 5) Pre-Op History and Physical 6) Asst. Surgeon Credentials (If Not M.D.)</p>	<p>B) DOCTOR'S HOSPITAL VISITS</p> <p>1) Hospital Progressive Notes 2) History and Physical Notes</p>	<p>C) DOCTOR'S OFFICE/ CLINIC VISITS</p> <p>1) Entire office notes of visit 2) History and Physical Notes</p>	<p>D) OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY</p> <p>1) Physical Therapy Notes and Radiology/Lab Report</p>
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Please be sure to address your envelope this way



Customer Service
P.O. Box 98029
Baton Rouge, LA 70898-9029

***For Blue Cross and Blue Shield of Louisiana Office Use Only:**

<input type="checkbox"/> Correspondence Unit	<input type="checkbox"/> Medical Review
<input type="checkbox"/> Provider Audit	<input type="checkbox"/> Reimbursement (Professional)
<input type="checkbox"/> Reimbursement (Facility)	<input type="checkbox"/> AR Sequence # _____