BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

Explanation of Reimbursement Review Form

Blue Cross and Blue Shield of Louisiana (BCBSLA) recognizes that there may be times when participating providers disagree with the way a claim was adjudicated. In those instances, providers may complete the Reimbursement Review Form, which can be found on the back of this *Speed Guide*. You can also download a copy of the form at www.bcbsla.com. The following information should help you complete the form.

1 Please check the box that best describes what type of provider you are.

Please Choose One:
❑ Professional ❑ Facility
❑ Allied Health ❑ Other

2 Please be sure to check the box on the Reimbursement Review Form that is your reason for appeal. We will not be able to help you without this information.

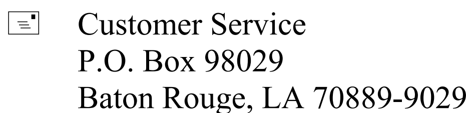
*REASON FOR APPEAL (Attach Additional Explanation If Necessary)
❑ Disagree with medical code editing and/or disagree with denial - i.e. assistant surgeon
❑ Claim not paid according to fee schedule and/or reimbursement amount is incorrect

- **Disagree with Medical Coding Edit or Denial (i.e. assistant surgeon)** – check this box if you disagree with how codes were bundled and/or denied. Please include your coding logic or applicable operative notes.
- **Claim not paid according to fee schedule and/or reimbursement amount is incorrect** – check this box if you believe that the wrong allowable charge amount was used to pay the claim. Please include the fee schedule amount that you believe should have been used.

3 Choose the box below that most closely matches the services you rendered and send the requested documentation to BCBSLA along with the Reimbursement Review Form. **Always include a hard copy of the claim.**

IF THESE SERVICES WERE RENDERED YOU MUST SUBMIT THE FOLLOWING INFORMATION:			
A) SURGERY, ASSISTANT SURGERY, ANESTHESIA	B) DOCTOR'S HOSPITAL VISITS	C) DOCTOR'S OFFICE/ CLINIC VISITS	D) OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
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.)	1) Hospital Progressive Notes 2) History and Physical Notes	1) Entire office notes of visit 2) History and Physical Notes	1) Physical Therapy Notes and Radiology/Lab Report

4 Once you've completed the form, please send it to the following address:



Customer Service
P.O. Box 98029
Baton Rouge, LA 70889-9029

If you have any questions, please call the *BlueLine* at 1-800-392-4076.

✱ ✱ ✱ Please always include a hard copy of the claim in question. ✱ ✱ ✱

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Post Office Box 98029
Baton Rouge, Louisiana 70898-9029

REIMBURSEMENT REVIEW FORM

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	

*REASON FOR APPEAL (Attach Additional Explanation If Necessary)

- ❑ Disagree with medical code editing and/or disagree with denial - i.e. assistant surgeon
- ❑ Claim not paid according to fee schedule and/or reimbursement amount is incorrect

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:

A) SURGERY, ASSISTANT SURGERY, ANESTHESIA	B) DOCTOR'S HOSPITAL VISITS	C) DOCTOR'S OFFICE/ CLINIC VISITS	D) OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
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.)	1) Hospital Progressive Notes 2) History and Physical Notes	1) Entire office notes of visit 2) History and Physical Notes	1) Physical Therapy Notes and Radiology/Lab Report

Please be sure to address your envelope this way

Customer Service
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Baton Rouge, LA 70898-9029

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

- ❑ Correspondence Unit
- ❑ Medical Review
- ❑ Provider Audit
- ❑ Reimbursement (Professional)
- ❑ Reimbursement (Facility)
- ❑ AR Sequence #____________

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company