



**BlueCross BlueShield
of Louisiana**

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



**HMO
Louisiana, Inc.**

A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.

APPEAL REQUEST FORM

Please submit this form and supporting information to:
Blue Cross and Blue Shield of Louisiana - Customer Service Unit
Appeals and Grievance Coordinator
P.O. Box 98045
Baton Rouge, La. 70898-9045

Person completing form: SUBSCRIBER PROVIDER
 SPOUSE AUTHORIZED DELEGATE
 PARENT/GUARDIAN (AN AUTHORIZED DELEGATE FORM MUST BE COMPLETED AND ATTACHED)

MEMBER INFORMATION			
NAME _____			
STREET ADDRESS _____			
CITY _____			STATE _____
HOME TELEPHONE NUMBER _____			DATE OF BIRTH _____
MEMBER CONTRACT NUMBER _____	MEMBER GROUP NUMBER _____	TYPE OF CONTRACT <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare Supplement	

APPEAL INFORMATION	
DATE(S) OF SERVICE 1. _____ 2. _____ 3. _____	SERVICE PROVIDER(S) INFORMATION (Hospital, physician, lab, etc) 1. Name _____ Address _____ Telephone Number (Including area code) _____ 2. Name _____ Address _____ Telephone Number (Including area code) _____ 3. Name _____ Address _____ Telephone Number (Including area code) _____
PROCEDURE OR TYPE OF SERVICE(S) DENIED _____ _____ Please attach any supporting clinical documentation you may be able to provide.	

REASON FOR APPEAL <input type="checkbox"/> Denied Inpatient Days <input type="checkbox"/> Not a covered benefit/policy exclusion <input type="checkbox"/> No Precertification / No Prior-Authorization <input type="checkbox"/> Other _____
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DESCRIPTION OF THE APPEAL / SUPPORTING INFORMATION (Please use additional pages as needed) _____ _____ _____ _____

MEMBER / AUTHORIZED DELEGATE SIGNATURE _____

DATE _____