



APPEAL REQUEST FOR NOT MEDICALLY NECESSARY/INVESTIGATIONAL DENIAL

In order to start this process, this form must be completed and submitted for review within 180 days of initial denial notification. Please submit this form with **your reason for appeal AND supporting documentation** to:

Blue Cross and Blue Shield of Louisiana
Attn: Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022
Fax: (225) 298-1837

Appeal Submitted By:

- Member
- Provider
- Authorized Representative **

MEMBER/PROVIDER INFORMATION

Member Name:	Provider Name:
Member ID #:	Provider Phone #:
Date of Birth:	Provider Fax #:
Service Being Appealed:	Provider Contact Name:
Reference Number (if available):	Date of Service:

SELECT APPEAL REQUEST TYPE

 Standard Appeal

Member/Provider/Authorized Representative**

Signature: _____ Date: _____

 Expedited/Urgent Appeal (Preservice and concurrent services only, not available for post-service)

Explain why you believe the patient needs the requested service and why the response time for the standard appeal process (up to 30 days) will harm the patient: _____

I certify, as the patient's treating physician, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health, or ability to regain maximum function or subject the patient to severe pain that cannot be adequately managed without the requested service.

MD Signature: _____ Date: _____

If an urgent/expedited appeal is submitted that does not meet the above criteria or does not have the physician attestation signature, the appeal will be processed as a standard appeal.

AUTHORIZED REPRESENTATIVE

If you want someone other than your provider to act on your behalf (authorized representative**), please sign below and have your authorized representative return it to us **with any other documentation about your case**. We cannot consider an appeal request if we do not have your signature giving us permission to work with someone else (other than you or your provider).

**Name of Authorized Representative (Print Name): _____

Member Signature: _____ Date: _____