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
- ❑ SPOUSE
- ❑ PARENT/GUARDIAN
- ❑ PROVIDER
- ❑ AUTHORIZED DELEGATE (AN AUTHORIZED DELEGATE FORM MUST BE COMPLETED AND ATTACHED)

MEMBER INFORMATION

NAME			
STREET ADDRESS			
CITY		STATE	ZIP CODE
HOME TELEPHONE NUMBER		DATE OF BIRTH	
MEMBER CONTRACT NUMBER	MEMBER GROUP NUMBER	TYPE OF CONTRACT ❑ Individual ❑ Group ❑ Medicare Supplement	

APPEAL INFORMATION

DATE(S) OF SERVICE

1. _____
2. _____
3. _____

PROCEDURE OR TYPE OF SERVICE(S) DENIED

_____

_____

Please attach any supporting clinical documentation you may be able to provide.

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) _____

REASON FOR APPEAL
- ❑ Denied Inpatient Days
- ❑ No Precertification / No Prior-Authorization
- ❑ Not a covered benefit/policy exclusion
- ❑ Other _____

DESCRIPTION OF THE APPEAL / SUPPORTING INFORMATION (Please use additional pages as needed)

_____

_____

_____

_____

_____ _____

MEMBER / AUTHORIZED DELEGATE SIGNATURE DATE