BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Provider Post-Service

Utilization Management Appeal Form

Post Office Box 10408 • Birmingham, AL 35202-0408 • Fax 205 220-9562

Section I: Patient Information

Alpha Prefix | **Contract Number** (Copy from the member's identification card) | **Patient Date of Birth** (mm/dd/yyyy)

Patient Name

First Name | Middle Inital | Last Name

Section II: Provider Information

Requesting Provider | **Requesting Provider's Signature**

Name | Signature

Fax | **Telephone**

BCBSAL Provider Number | **Provider's National Provider Identifier (NPI)**

Provider Mailing Address & Office Contact Person

Street Address or P.O. Box

City | State | Zip | Office Contact Person

Section III: Appeal Information

Date of Service (mm/dd/yyyy)

Procedure Code 1 | **Diagnosis Code 1**

Procedure Code 2 | **Diagnosis Code 2**

Claim Identification Number

Blue Cross and Blue Shield of Alabama action prompted this appeal. (Please check one)

ADMINISTRATIVE RECONSIDERATION

☐ PT ☐ Inpatient Hospital ☐ OT ☐ Outpatient ☐ ST ☐ DME ☐ Chiropractor ☐ Inpatient Rehab
☐ Behavioral Health ☐ Home Health

Comments

☐ Medical Record attached

Clear Form