Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, RI 02903-2699
(401) 459-1000 www.bcbsri.com

Physician/Provider Appeal Request Form

THIS FORM DOES NOT APPLY when submitting a **corrected claim / claim adjustment**, such as:

- Other carrier EOB within 180 days of retraction
- Corrected claim within 180 days of denial disposition
- Corrected claim within 18 months of paid dispositions (Commercial only)
- Claim not on file

For instances above, please utilize the Claim Adjustment Request Form

Use one form per member to request an appeal of a denial

Member Name:_____ Provider Name: _____

Member ID#: _____ Group Name: _____

Date of Service: National Provider Identifier (NPI): _____

Claim Number: _____ Phone: (_____) _____

Office Contact Person: _____

Is this a Workers' Compensation Claim? ☐ Yes ☐ No

Is this a FEP Claim (Member ID Number begins with single letter 'R')? ☐ Yes ☐ No

Please check one; Reason for Appeal:

☐Timely Filing (claim not filed within TF guidelines)

☐ Service not in Provider's Contract **or** not within 180 days after another payer's settlement*

☐ Pre-Auth was denied during Initial Review

☐ Administrative Claim Denial **(Claims Edits)**

☐ Investigational/Experimental/Not Medically Necessary Denial

☐ Provider not authorized for the service

☐ Other: _____

Notes:

*Do not highlight line items on settlements. Use asterisks to identify relevant line items on your settlements. To comply with HIPAA, all other non-pertinent PHI on attached settlements must be blacked out. Use one appeal form per member.

Additional Comments: _____

Submit Appeals:

- **Through our secure provider portal**
- **Email: GAU_Complaints_Appeals@bcbsri.org**
- **Fax: 401- 459-5668 (Medicare)**

401- 459-5005 (all other lines of business)

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