BlueCross BlueShield of Illinois

BLUE MEDICARE ADVANTAGE HMO
A Blue Cross HMO

Blue Medicare Advantage HMO - Past Due Claims Appeal Form

(Form must be filled out completely to be considered for appeal)

Date: _____ MG/IPA#: _____

ID #: _____ SSN: _____

Name: _____

Service Date: _____ Billed _____

Provider Name: _____ Claim #: _____

Did you receive the PDC notice? ☐
(Must be Yes or No)

Did you respond to the PDC notice? ☐
(Must be Yes or No)

(Section below must be completed to receive cap reimbursement if appeal is approved)

☐ Provider was capitated for these services. Provider was called and instructed not to bill the member again. Capitated on: Provider was called on:

☐ Stale dated claim. Provider was called on & instructed to write off charges.

☐ Claim was paid: Date paid: Check #:

☐ Not Group Approved

☐ **Other :**

Reply Section - To be completed by the HMO

Appeal Approved: Appeal Denied:

Explanation:

Completed by: _____ Date Completed: _____