An Independent Licensee of the Blue Cross and Blue Shield Association

# PROVIDER Grievance Form

(This is an OPTIONAL form.)

**Send to**: BCBSAZ, P.O. Box 13466, Phoenix, AZ, 85002

Date ________ Name of Provider ______________________________Provider NPI # or Tax ID ____________________

Mailing Address______________________________________________________________________________________

City ___________________________________________________ State ____________ ZIP Code __________________

Contact Person ____________________________________________Phone # _________________________________

Member Name _________________________________________ Member ID # __________________________________

Date(s) of Service ___________________ Claim # ______________________ Patient Account # ___________________

**Plan or Account Name and Alpha Prefix**

☐ **BCBSAZ** – Includes all **XB_** alpha prefixes. Other employer group-specific alpha prefixes may be assigned to certain 100+ groups. Refer to the BCBSAZ Alpha Prefix Grid on azblue.com for a listing of additional alpha prefixes.

☐ **Federal Employee Program (FEP)** – Alpha prefix "R" followed by eight numeric characters.

☐ **BlueCard (Out-of-state)** – Note: The minimum three letter alpha prefix varies by Blue Plan. Please send all BlueCard grievances directly to BCBSAZ. BCBSAZ will handle disputes related to claims coding and pricing, and will forward all other disputes to the Home plan for resolution.

☐ **CHS** – **pricing related disputes only.** No alpha prefix in front of ID #. The TPA is responsible for handling all appeals from providers, and *any grievances from providers that are not pricing related*

**Reason for Grievance** – Please provide a detailed description of the issue and include appropriate documentation to support your position (medical records, operative report, etc.)

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Please check appropriate box: ☐ Level 1 Grievance ☐ Level 2 Grievance