ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER APPEAL FORM
PO Box 33200
Louisville, Kentucky 40232-3200

With the exception of appeals of adverse Precertification decisions, all requests for review must first be submitted to the appropriate Provider Inquiry Unit as a complaint. If you are not satisfied with our response to your complaint, you may request an appeal. A Participating Provider's request for Anthem Blue Cross and Blue Shield (Anthem) to change a reimbursement amount for a service, including disputes regarding bundling, and coding, shall be handled exclusively as a Complaint. To avoid unnecessary delays in the handling of your appeal, please include a copy of our written response to your complaint regarding the issue being appealed.

DATE: _____/_____/_____ MEMBER ID NUMBER: _____

MEMBER NAME _____ PATIENT NAME _____

DATE OF SERVICE _____DATE PAID _____

ANTHEM CLAIM NUMBER _____

REASON FOR APPEAL (Please be specific and attach additional pages, if necessary).

_____

_____

_____

THE FOLLOWING DOCUMENTATION IS ENCLOSED FOR REVIEW OF THIS APPEAL:

CLAIM FORM _____ OFFICE NOTES _____ PAYMENT VOUCHER _____MEDICAL RECORDS _____

X-RAYS _____ OTHER _____

****

PHYSICIAN/FACILITY NAME: _____

PHYSICIAN/FACILTIY ADDRESS _____

CITY _____STATE _____ ZIP _____ COUNTY _____

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PROVIDER TELEPHONE NO (____) _____PROVIDER ID NO. _____

DATE OF COMPLAINT RESPONSE _____

PHYSICIAN/HOSPITAL SIGNATURE _____