BlueCross BlueShield of Texas *

Physician/Professional Provider & Facility/Ancillary Request For Claim Appeal/Reconsideration Review Form

Do not attach claim forms unless changes have been made from the original claim that was submitted. Please attach supporting documentation to facilitate your review, for example the operative report, or medical records, etc. This form must be placed on top of the correspondence you are submitting.

Reason for Review	Please check one of the boxes below: ☐ Refund Dispute ☐ Corrected Claim Attached ☐ Appeal ☐ Other ☐ Response to Medical Records Request ☐ Voluntary Submission of Medical Records

Please include detailed information as to the nature of your claim appeal/reconsideration review. If a corrected claim has been attached, please specify corrections that were made.

Please mail to the following address

ParPlan/BlueChoice®	ParPlan/BlueChoice, P. O. Box 660044, Dallas, Texas 75266-0044
Federal Employee Program (FEP)	FEP, P. O. 660044, Dallas Texas, 75266-0044
HealthSelect℠	HealthSelect Customer Service, P.O. Box 660044, Dallas, Texas 75266-0044
HMO Blue® Texas	HMO Blue Texas, Customer Service, P.O. Box 660044, Dallas, Texas 75266-0044

Claim Data:

Identification Number (Include the three-digit prefix)		**Group #**
Member's Name		
Patient's Name		
Date(s) of Service		
Billed Amount		
BCBSTX/HMO Blue Texas DCN or Claim Number		

Physician/Professional Provider or Facility/Ancillary Provider Data:

National Provider Identifier (NPI) Number(s)		**Today's Date**
Physician/Professional Provider or Facility/ Ancillary Name		
Address		
Contact Person		**Phone # ( )**

updated 5/2008