Appeal Request Form

This form is to be used when a provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.

Payer name and address, allow for formatting in window envelope for paper submission.

Blue Cross/Blue Shield MN Appeals
PO Box 64560
St. Paul, MN
55164-0560

Billing Provider Information:

Name:

ID Number:

Patient Account Number:

Claim Information:

Patient Name:

Patient ID Number:

Date(s) of Service:

Payer Claim Number**:**

Property and Casualty or
Workers Compensation Claim Number:

Reason for Appeal Request:

☐ Timely Filing ☐ Pricing ☐ Eligibility ☐ Medical Policy ☐ Code Review ☐ Other

Complete description of reason for claim appeal.

Supplemental Documentation:

☐ Remittance Advice ☐ Spreadsheet ☐ Refund ☐ Medical Records

☐ Other (describe):

Contact Information:

Requester: Individual requesting appeal

Date: Date of appeal request

Contact Number: Phone, fax or email should be supplied for entity requesting appeal

Address:

Total number of pages: