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  Network Participation

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  Education and Reference

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  Clinical Resources

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  Standards and Requirements

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    - Clinical Payment and Coding Policies
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# Claim Review and Appeal

*The following information does not apply to Medicare Advantage and HMO claims. It is provided as a general resource to providers regarding the types of claim reviews and appeals that may be available for commercial and Medicaid claims. Participating providers should refer to their participating provider agreement and applicable provider manual for information on specific provider claim review or appeal rights.*

## Requesting a Claim Review

After adjudication, additional evaluation may be necessary (such as place of treatment, procedure/revenue code changes, or out-of-area claim processing issues).

**Electronic claim reconsideration** requests are available for review and/or reevaluation of situational finalized claim denials online (including BlueCard® out-of-area claims). This method of inquiry submission is **preferred over faxed/mailed claim disputes**, as it allows you to upload supporting documentation and monitor the status via Availity® Essentials.

For more details, refer to the Claim Reconsideration Requests page and instructional user guide in the Provider Tools section of our website.

For providers who need to submit claim review requests via paper, one of the specific Claim Review Forms listed below must be utilized. Each Claim Review Form must include the BCBSIL claim number (the Document Control Number, or DCN), along with the key data elements specified on the forms.

- Claim Review Form – Commercial only
- Additional Information Form – Commercial only
- Corrected Claim Form – Commercial only
- Medicaid Claims Inquiry or Dispute Request Form – Medicaid only

## Non-Participating Providers

Claims for certain services may be eligible for payment review under the No Surprises Act if you don’t have a contract with us. **Log on to** Availity Essentials **to request a claim review and initiate a negotiation** for NSA-eligible services. See our user guide for more details.

## Commercial Appeals

For more information related to Government Program appeals, please reference applicable provider manuals.

A **provider appeal** is an official request for reconsideration of a previous denial issued by the BCBSIL Medical Management area. *This is different from the request for claim review request process outlined above.* Most provider appeal requests are related to a length of stay or treatment setting denial.

- Appeals may be initiated in writing or by telephone, upon receipt of a denial letter and instructions from BCBSIL.
- A routing form, along with relevant claim information and any supporting medical or clinical documentation must be included with the appeal request.
- The physician/clinical peer review process takes 30 days and concludes with written notification of appeal determination.

A **member appeal** may be submitted by the member or their authorized representative, physician, facility or other health care practitioner. Written or verbal authorization from the member is required with the exception of urgent care appeals. Brief descriptions of the various member appeal categories are listed below.

- **A clinical appeal** is a request to change an adverse determination for care or services that were denied on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic. May be pre- or post-service. Review is conducted by a physician. Electronic clinical appeal requests for specific clinical claim denials may be submitted via Availity. When applicable, the **Dispute Claim** option is available after completing an Availity Claim Status request. See the Electronic Clinical Claim Appeal Request page in our Provider Tools section of our website for more information.
- **A non-clinical appea**l is a request to reconsider a previous inquiry, complaint or action by BCBSIL that has not been resolved to the member's satisfaction. Relates to administrative health care services such as membership, access, claim payment, etc. May be pre-service or post-service. Review is conducted by a non-medical appeal committee.
- **Urgent care or expedited appeals** may be requested if the member, authorized representative or physician feels that non-approval of the requested service may seriously jeopardize the member's health. The physician or facility may request an expedited appeal by calling the number on the back of the member's ID card.

*Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.*

**Related Resources**

- Clear Claim Connection™

## Insurance Basics

- Health Care Costs
- Types of Health Insurance Coverage
- Get Free In-Person Help
- Glossary
- FAQs

## Buying a Health Plan

- How to Enroll for Health Insurance
- Get a Quote/Browse and Buy Plans
- Premium Tax Credit Estimator
- Individual & Family Plans
- Medicare Plans

## Member Resources

- Log in to Blue Access for Members
- Register for Blue Access for Members
- Pay My Bill
- Federal Employee Program (FEP)

- Legal and Privacy

- Non-Discrimination Notice
- Careers
- Contact Us
- Newsroom

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