BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Mail to the address listed in the corresponding appeal instructions

Provider Appeal Form

Please complete the following information and return this form with supporting documentation to the applicable address listed on the corresponding appeal instructions. Send only one appeal form per claim. Appeals must be submitted within one year from the date on the remittance advice.

Date ____________________

Appeal Type (check one)

☐ Utilization Management (see below)	☐ Adverse Determination	☐ Coding and Payment Rule	☐ Other

If a Utilization Management appeal, complete the following:

Type: ☐ Authorization ☐ Precertification	Authorization or Precertification Number

1. Provider Information

Provider Name Josee Arcand		Provider Number 28446	
Street Address 21 Suntree Pl, Ste 102		City Melbourne	State Fl / Zip 32940
Telephone Number (321) 255-7334	Fax Number (321) 255-7336	Contact Name Chris	

2. Patient Information

Patient Last Name	Patient First Name
Contract/ID Number (alpha prefix and numbers)	Patient Date of Birth
Subscriber Last Name	Subscriber First Name

3. Claim Information

Claim Number	Product (e.g., BlueCare, BlueOptions, etc.)
Billed Amount	Date(s) of Service (From) (To)
Procedure Code(s):	

4. Appeal Reason (Explain the reason for the appeal in the space below.)

Supporting Documentation

The following supporting documentation must be attached to this form:

1. Copy of the remittance advice or member's explanation of benefits. Indicate the code(s) or service(s) being appealed.
2. Medical documentation related to the appeal (medical records, operative report, inpatient or emergency room face sheet etc.) See applicable instructions for your appeal type.
3. Any additional documentation.