

## CLAIM RECONSIDERATION REQUEST COVER SHEET – PROVIDER REQUESTS

**ATTACH EXPLANATION FOR REQUEST AND SUPPORTING DOCUMENTATION TO COVERSHEET**

**INSTRUCTIONS:** Submit a separate form for each member. This cover sheet is to be completed by physicians, hospitals, or other health care professionals to request a claim reconsideration or appeal on members enrolled in Arkansas Blue Cross or Health Advantage Plans. There are two stages available; 1) Claim Reconsideration and 2) Formal Provider Appeal. If you disagree with the processing of a claim, the **first step is the submission of a 1<sup>st</sup> Level - Claim Reconsideration Request to Medical Re-review**. If you disagree with the claim reconsideration decision, you may then submit a 2<sup>nd</sup> Level - Formal Provider Appeal. **Do NOT use this form for submitting new or corrected claims, requesting timely filing exceptions, responding to bar code request letters for medical information, or submitting coordination of benefits information.** Please be sure to attach all pertinent information to support your request. If requesting a 2<sup>nd</sup> Level – Formal Provider Appeal, please be sure to include a copy of the determination response from the 1<sup>st</sup> Level – Claim Reconsideration Request.

### Request Information

Line of Business (Select One):	<input type="checkbox"/> Arkansas Blue Cross and Blue Shield	<input type="checkbox"/> Health Advantage
Request Level (Select One):	<input type="checkbox"/> 1 <sup>st</sup> Level – Claim Reconsideration Request	<input type="checkbox"/> 2 <sup>nd</sup> Level – Formal Provider Appeal
Reason For Request (attach explanation for request and supporting documentation):		
<input type="checkbox"/> Pricing Issue	<input type="checkbox"/> Fragmented Charge Denial – Fragmented or “bundled claim” issue	
<input type="checkbox"/> Resubmission of “Prior Notification Information”	<input type="checkbox"/> Other: _____	

### Provider Information

Type of Provider: <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Other health care professional (Lab, DME, etc.)	Date Form Completed:	
NPI # or Tax ID:	Return Address:	
Provider Name (as listed on RA/EOB):		
Facility/Group Name:	Contact Person:	Phone Number: (     )

### Member Information

Member ID#		
Member's Name:	Denial Reason:	CPT Code at Issue:
Claim #:	Date of Service:	Billed Amount:

### Provider Mailing Instructions

<p><i>1<sup>st</sup> Level Reconsiderations</i> For <b>Arkansas Blue Cross</b>, mail request to:</p> <p>Arkansas Blue Cross and Blue Shield Attn: Medical Re-review PO Box 3688 Little Rock, AR 72203-3688</p>	<p><i>2<sup>nd</sup> Level – Formal Provider Appeals</i> For <b>Arkansas Blue Cross</b>, mail request to:</p> <p>Arkansas Blue Cross and Blue Shield Attn: Appeals Coordinator PO Box 2181 Little Rock, AR 72203-2181</p>	<p><i>1<sup>st</sup> Level and 2<sup>nd</sup> Level requests</i> For <b>Health Advantage</b>, mail request to:</p> <p>Health Advantage Attn: Member Response Coordinator PO Box 8069 Little Rock, AR 72203-8069</p>
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