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 *1st Level - Claim Reconsideration Request* to Medical Re-review**. If you disagree with the claim reconsideration decision, you may then submit a *2nd 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 *2nd Level – Formal Provider Appeal*, please be sure to include a copy of the determination response from the *1st Level – Claim Reconsideration Request*.

Request Information

Line of Business (Select One):	☐ Arkansas Blue Cross and Blue Shield	☐ Health Advantage
Request Level (Select One):	☐ **1st Level – Claim Reconsideration Request**	☐ **2nd Level – Formal Provider Appeal**

Reason For Request **(attach explanation for request and supporting documentation)**:

☐ Pricing Issue ☐ Fragmented Charge Denial – Fragmented or "bundled claim" issue

☐ Resubmission of "Prior Notification Information" ☐ Other: _____

Provider Information

Type of Provider: ☐ Physician ☐ Hospital ☐ 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

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

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