



**MEDICARE NON-CONTRACT PROVIDER  
POST SERVICE APPEAL FORM**

This form is intended for use only when a non-contract provider is requesting a review of a service that has been provided to a Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Medicare Advantage member and payment of a claim was denied.

Please submit any supporting documentation along with this form to: **BlueCross BlueShield of North Carolina, Attn: Medicare Appeals and Grievances, P.O. Box 1291, Durham, NC 27702-1291. The Waiver of Liability form included in this document must be completed and submitted along with the appeal request.**

**Section I: Patient Information**

|                           |                       |                              |
|---------------------------|-----------------------|------------------------------|
| <b>Subscriber ID</b>      |                       | <b>Patient Date of Birth</b> |
| <b>Patient First Name</b> | <b>Middle Initial</b> | <b>Patient Last Name</b>     |

**Section II: Physician Information**

|   |                             |                   |
|---|-----------------------------|-------------------|
| <b>Requesting Physician</b> (Print first name, last name) | <b>Physician NPI Number</b> |                   |
| <b>Phone Number</b>                                       |                             | <b>Fax Number</b> |
| <b>Physical Mailing Address</b> (Street or P.O. Box)      | <b>City, State</b>          | <b>Zip Code</b>   |

**Section III: Appeal Information**

|  |  |
|--|--|
| <b>Date of Service</b> (Month, Day, Year)  | <b>EOP Date of Notification of Denial</b> (Month, Day, Year) |
| <b>CPT Codes</b>   | <b>Diagnosis Codes</b>                                       |
| <b>Claim Identification Number</b>   |  |
| <b>APPEAL REASON</b> (Please state reason for appealing and attach any additional information you believe may help your case): Please use additional pages if necessary. |  |

**WAIVER OF LIABILITY STATEMENT**

PO Box 2291, Durham, NC 27702-2291

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\_\_\_\_\_  
**Enrollee's Name**

\_\_\_\_\_  
**Enrollee ID Number**

\_\_\_\_\_  
**Provider**

\_\_\_\_\_  
**Dates of Service**

\_\_\_\_\_  
**Health Plan**

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Blue Cross and Blue Shield of North Carolina is an HMO and PPO plan with a Medicare contract.  
Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.  
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