Commercial and Medicare Provider Coding Disputes Form

NOT to be used for Federal Employee Program (FEP)

Note: This form is intended for use only when requesting a review of a post service claim denied for coding/bundling denials. Provider Coding Disputes should be accompanied by any supporting documentation. Please complete the form in its entirety.

Note: If you are acting on the member's behalf and have a signed BlueCross NC appeal authorization from the member or you are appealing a pre-authorization denial and the services have yet to be rendered, DO NOT USE THIS FORM. Please follow the member appeal process for appeal requests on behalf of the member as outlined at ***https://www.bluecrossnc.com/providers/medical-policies-and-coverage/member-appeal-representation-authorization-form#search=Member Appeal Members.*** The Blue Cross NC authorization form should be submitted with a written appeal request or with the member appeal form if appealing on behalf of member.

Today's Date	**Member's ID Number**	**Member's Group Number (Optional)**
Member's First Name[1]	**Member's Last Name**	**Member's Date of Birth**
Provider Name	**Provider Number/NPI**	
Provider Group Name (If applicable)	**Office Contact**	**Contact Mailing Address**[2]
Contact Phone Number	**Contact Fax Number**	**Contact Email Address (optional)**

To help BlueCross NC review and respond to your request, please provide the following information below. (*This information may be found on prior correspondence you received from BlueCross NC.*) You may use this form to dispute multiple dates of service for the same member.

Claim Number(s)[3]	**Date(s) of Service(s)**
CPT/HCPCS Code of Service Being Disputed	
Explanation of Your Request (*Please use additional pages if necessary*)	

For Provider Coding Disputes, please fax your request with all supporting documentation and medical records to:

Commercial Billing/Coding Denials: 919-2878708
Medicare Billing/Coding Denials: 336-659-2947

If documentation needs to be sent to Blue Cross NC by mail, please send to:
Provider Appeal Department, P.O. Box 2291, Durham, NC 27702-2291

1. Provide the member's first and last name — unless the member is a newborn. In that case, the name could be either the subscriber's or spouse's name, or the newborn's name.
2. Address can be incomplete, but field cannot be left blank
3. Field can be incomplete, but cannot be left blank