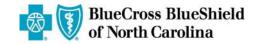
NON-CONTRACT PROVIDER POST SERVICE APPEAL FORM FOR BLUE MEDICARE HMOSM



AND BLUE MEDICARE PPOSM

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Section I: Patient Information	
Alpha Prefix (Copy from the member's BCBSNC identification card)	ent Date of Birth
Subscriber Number (Copy from the member's BCBSNC identification card)	
Patient Name (First, middle initial, last)	
Section II: Physician Information	
Section II: Physician Information	
Requesting Physician (Print first, last name) Requesting	ng Physicians Signature (Signature & date)
	Phone
Fax	
Physician NPI Number	
Physician Mailing Address (Street or P.O. Box, City, State & Zip Code)	
Section III: Appeal Information	
	OP Date of Notification of Denial
CPT Codes	Diagnosis Codes
Claim Identification Number	

APPEAL REASON (Please state reason for appealing and attach any additional information you believe may help your case): If additional space is needed, please use the back of this 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 BCBSNC Medicare Advantage member and denied. Completed forms, must include the Waiver of Liability form, and any supporting documentation (a copy of the original claim, denial notice, and/or any clinical records), and should be sent to: Blue Medicare HMOSM and Blue Medicare PPOSM, Attn: Non Contract Appeals and Grievances, P.O. Box 17509, Winston-Salem, NC 27116-7509. Please refer to the Blue Medicare HMOSM and Blue Medicare PPOSM Non- Contract provider section located on the BCBSNC Web site for providers at <u>www.bcbsnc.com/providers/</u>