BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

CURP Acute Inpatient Appeal Form

Post Office Box 360167
Birmingham, AL 35236-0167
Fax 205-220-0113

Utilization of this appeal form is for acute inpatient hospital denials in an Alabama CURP facility only. Do not use this form for outpatient services, LTACH, Acute Rehabilitation or Skilled Nursing Facility denials.

Section I: Patient Information

Alpha Prefix	Contract Number (Copy from the member's identification card)	Patient Date of Birth (mm/dd/yyyy)
		– –

Patient Name

First Name	Middle Initial	Last Name

Section II: Provider Information

Requesting Provider	Requesting Provider's Signature
Name	Signature

Fax	Telephone
– –	– –

BCBSAL Provider Number	Provider's National Provider Identifier (NPI)
–	

Provider Mailing Address & Office Contact Person

Street Address or P.O. Box

City	State	Zip	Contact Person

Section III: Appeal Information

Claim Identification Number

Tracking Number	Admission Date
	– –

Dates of Service – – **Through** – –

Reason for Appeal

Attach Medical Records

Attach medical records with this request, including any new or additional information, to facilitate an appropriate medical decision.

☐ Medical records attached

Comments