BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Consolidated Appropriations Act

Open Negotiations Intake Form

Section I: Patient Information

Fax completed form to 205-733-7284

Contract Number (Copy from the member's identification card)

Patient Date of Birth (mm/dd/yyyy) __ __ - __ __ - __ __ __ __

Patient Name

First Name	Middle Inital	Last Name

Section II: Requesting Provider Information

Name	Speciality

Fax ___ - ___ - ____ **Telephone** ___ - ___ - ____

Provider's National Provider Identifier (NPI)

Provider Mailing Address, Email and Office Contact Person

Street Address or P.O. Box	City	State	Zip

Office Contact Person	Email Address

Section III: Procedure Information

Date of Service __ __ - __ __ - __ __ __ __

Procedure Code 1 _____ - __

Procedure Code 3 _____ - __

Procedure Code 2 _____ - __

Diagnosis Code 1 ___ . ____

Claim Identification Number

ADMINISTRATIVE RECONSIDERATION

Select the reason for reconsideration:

- Initiate Open Negotiation **(Fax)**
- Independent Dispute Resolution Notice
  Submit via email: OpenNegotiationIDR@bcbsal.org

Select your provider type:

- Outpatient/ASC Facility
- Inpatient/Facility
- Physician/Professional
- Ambulance

By signing this form, I agree to initiate this request.

Signature ______________________ Date ______________

Be sure to attach medical records, if applicable.

Medical Record attached

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