BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Provider Post-Service

Claims Reconsideration Form

Post Office Box 10408 • Birmingham, AL 35202-0408 • Fax 205 220-9562

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 Inital	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	Office Contact Person

Section III: Appeal Information

Date of Service (mm/dd/yyyy) - -

Procedure Code 1	-	**Diagnosis Code 1**	.
Procedure Code 2	-	**Diagnosis Code 2**	.

Claim Identification Number

Blue Cross and Blue Shield of Alabama action prompted this appeal. (Please check one)

ADMINISTRATIVE RECONSIDERATION

☐ Coordination of Benefits ☐ Coverage/Benefits ☐ Coinsurance/Deductible ☐ Eligibility ☐ Global Maternity
☐ Modifier Review ☐ 24 ☐ 54 ☐ 55 ☐ 56

Comments

☐ Medical Record attached

PRO80-2209

Clear Form