PROVIDER INTERNAL POST-SERVICE CLAIM APPEAL PROCESS

Questions & Answers

What is an appeal? *An appeal is when a provider formally requests (via appeal form or letter) a reconsideration of a previously adjudicated claim from the contracting Blue Plan, which may or may not require additional information. Applies to Blue Cross and Blue Shield of Alabama members and out-of-state members receiving services in Alabama.* ***Does not apply to Blue Advantage® (PPO)****.*

Examples of appeals include, but are not limited to:

- Payer allowance
- Medical necessity (including cosmetic and investigational)
- Incorrect payment/coding rules applied
- Errors in administration of coordination of benefits (COB), coinsurance/deductibles, coverage/benefits,eligibility, timely filing

Following are examples of what is not considered a provider appeal:

- Corrected claim
- Provider complaints regarding medical policy
- Contracting issues
- General inquiries/questions
  - Provider request to "review" a claim
  - Pricing issue not associated with a post-service claim
  - Scope of practice
- Any claim denied needing additional information
- Unsolicited medical records
- Provider appeal on behalf of member (see member appeal process)
- Notes written on copies of claim forms or provider remittances without supporting documentation

When can I request an appeal?

Blue Cross will perform a single internal appeal as a courtesy to the provider when there is an adverse benefit determination as described above. Providers should also refer to their Participating or Preferred Provider Agreement for dispute resolution options.

How long do I have to submit an appeal?

Consideration will not be given to appeals received greater than 180 days from the claim adjudication/denial date.

Is requesting a claims review through Customer Service the same as requesting an appeal?

No. Refer to the section "How do I request an appeal?" for the appropriate appeals request process.

* Not applicable to predeterminations, provider audits or appeals regarding termination from network.

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How do I request an appeal?

Providers should submit a formal request via the appropriate form developed for provider usage. A letter, on letterhead, may accompany the form and contain:

- The reason for the appeal
- The patient's name
- The patient's contract number
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure and claim number

Please be sure to include any supporting information or explanation, including any relevant procedural notes, chart notes and/or medical records appropriate to the review. Forms must be properly completed and letters must contain all relevant information to be processed as an appeal. Completed forms must include the provider signature. Incomplete forms and letters will not be processed.

How do I request bulk appeals?

Bulk appeals must be requested through your Provider Networks Consultant. Bulk appeals will not be processed unless approved by your Provider Networks Consultant.

Where do I send my appeal request?

All appeal correspondence should be submitted to the following:

Blue Cross and Blue Shield of Alabama Appeals

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

What if I disagree with an initial appeal determination?

If the provider has completed the initial internal appeal,any subsequent appeal rights will be defined by his orher Participating or Preferred Provider Agreement or legal settlement in effect.

BlueCross BlueShield of Alabama

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