

Appeal Form for Provider Billing Dispute and Medical Necessity Denial

Physicians and other health care professionals may appeal a Regence claim payment decision by completing this form and faxing it to the number below along with any supporting documentation.

This form is appropriate for a dispute between a provider and Regence about: (i) application of coding and payment rules and methodologies for fee for service claims submitted for payment (e.g., bundling, downcoding or application of a CPT modifier) or (ii) a denial stating a service is not medically necessary.

Please do **not** use this form to submit a corrected claim or a member appeal.

Date: _____	Provider Office Contact: _____
Provider Tax ID: _____	NPI #: _____
Provider Name: _____	Telephone Number: _____
Provider Billing Address: _____	
Member Name: _____	Member Date of Birth: _____
Member ID# (include alpha prefix, if known): _____	
Claim Number(s): _____	Date(s) of Service: _____
Has this claim(s) been appealed to Regence before?	
___ Yes. If yes, please supply a copy of the appeal determination letter.	
___ No	

Include the following information when submitting this form:

- Reason for appeal
- Outcome desired
- Regence appeal determination letter if this claim has been appealed before
- Supporting documentation. Examples include:
 - Operative report(s)
 - AMA-related article(s)
 - Chart notes

Fax to: 1 (866) 273-1820



Regence

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