Claim reconsideration request cover sheet | Provider requests

Attach explanation for request and supporting documentation to coversheet

Instructions: For contracting providers, use of this form to review a claim denial or payment amount without the inclusion of a signed Authorized Representative Form will result in a post-service claim adjudication review that is performed outside of the rules, regulations, and guidelines governing the CMS regulated Member Appeal process. It will not result in a review under the CMS regulated Member Appeal process. Unlike the CMS Member Appeal process, there is only one level of review available. For non-contracting providers who seek to obtain the review of a claim denial, a signed Waiver of Liability Form must be submitted and the review request will only be processed under the CMS regulated Member Appeal Process. **Submit a separate form for each member**. Please be sure to attach any explanation and supporting documentation you would like reviewed. Do not use this form for submitting new or corrected claims, responding to bar code request letters for medical information, or submitting coordination of benefits information.

Request information

Line of business Arkansas Blue Medicare	**Date form completed**
Reason for request (attach explanation for request and supporting documentation)	

Provider information

Type of provider Physician Hospital Other health care professional (Lab, DME, etc.)	**NPI number or Tax ID**
Provider name (as listed on RA/EOB)	**Facility/Group name**

Return address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

Member and claim information

Member ID number	
Member's name	
Denial reason	
CPT code at issue	**Billed amount**
Claim number	**Date of service**

Return completed form and supporting documentation to:
Medicare Advantage Legal Appeals Department
PO Box 2181
Little Rock, AR 72203
or
Fax: 501-378-3366
Email: appealscoordinator@arkbluecross.com

Arkansas Blue MEDICARE

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