Anthem BlueCross BlueShield

BadgerCare Plus

Claim Payment Appeal– Submission Form

This form should be completed by providers for payment appeals only.

MEMBER INFORMATION:

Member First/Last Name____
Member Date of Birth _________________
Member Coverage: □ Medicaid □ Medicare

PROVIDER/PROVIDER REP INFORMATION:

Provider First/Last Name__________________________________ NPI#_______________________

Provider Street Address____

City_________________________________ State______ Zip_____________

□ I am a participating provider □ I am a nonparticipating provider*

*If filing for a Medicare member and the member has potential financial liability, you must include a completed Centers for Medicare & Medicaid Services (CMS) Waiver of Liability form.

Provider Representative: □ Self □ Billing Agency □ Law Firm □ Other: ________________________

CLAIM INFORMATION*:

Claim #_______________________ Billed Amount $____________
Amount Received $_________________

* If you have multiple claims related to the **same** issue, you can use one form and attach a listing of the claims with each supporting document following behind.

PAYMENT APPEAL

A payment appeal is defined as a request from a health care provider to change a decision made by Anthem related to claim payment for services already provided. A provider payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

□ First-Level Appeal □ Second-Level Appeal

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To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination that was provided on the Anthem determination letter or Explanation of Payment (EOP).

□ Un-Timely Filing	□ Claim code editing denial	□ Denied as duplicate
□ No Authorization	□ Retrospective Authorization Issue	□ Denial related to provider data issue
□ The claim denied for OHI, but member doesn't have OHI	□ Disagree that you were paid according to your contract	□ Member retro-eligibility issue
□ Experimental/Investigational procedure denial	□ Data elements on the claim on file does not match the claim originally submitted	□ Other: ______________________________ ______________________________

Mail this form, a listing of claims (if applicable) and supporting documentation to:

Claim Appeals
Anthem Blue Cross and Blue Shield
P.O. Box 61599
Virginia Beach, VA 23466-1599