

## 1 INSTRUCTIONS

Submit this form within six months of the date your claim was processed or the adverse benefit determination (denial) was made.

**Member Portal**  
Submit via your secure member account at [myNebraskaBlue.com](http://myNebraskaBlue.com) under the *Contact Us* tab

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⋮  
**or**  
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**Mail to**  
Appeals Department  
BCBSNE  
P.O. Box 3248  
Omaha, NE 68180-0001

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⋮  
**or**  
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**Fax to**  
402-548-4684 or  
888-492-4944

## 2 DETAILS

Requester Name: \_\_\_\_\_ Requester Phone: \_\_\_\_\_

Relationship to Patient:    Self          Provider          Authorized Rep          Other: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Provider/Facility: \_\_\_\_\_

Date of Service: \_\_\_\_\_ BCBSNE Claim Number: \_\_\_\_\_

Denial Reason:

- |                            |                              |                                       |   |
|----------------------------|------------------------------|---------------------------------------|---|
| Not Medically Necessary    | Contractual Exclusion/Limits | Claim/Payment Issue                   | No Preauthorization/<br>Precertification Obtained |
| Investigative/Experimental | Cosmetic                     | Other (explain in<br>Summary section) |   |

Type of Review (description below):    Standard          Expedited

**Standard Review:** May involve prospective/pre-service, concurrent care and admission/observation where the service has already been rendered or there are claims involved. The appeal must be requested in writing.

**Expedited Review:** Pertains to a claim involving immediate care. An internal appeal should be handled on an expedited basis if a delay would jeopardize the life or health of the patient, would jeopardize the patient's ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If definition for expedited review is not met, the appeal may be completed at the standard level appeal. The appeal may be requested in writing or by calling the Appeals department at 402-982-8314 or 877-448-3339.

**3 SUMMARY**

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Provide a brief description of the disagreement. Clearly indicate the service(s) and specific date(s) being denied and why you disagree with that decision. Attach additional pages if necessary. Please include available pertinent medical records, office notes, operative reports, peer literature or additional information from your health care provider, as well as any information received from Blue Cross and Blue Shield of Nebraska (BCBSNE) concerning the claim, such as the Explanation of Benefits (EOB).

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