

Appeal Request

Form must be complete, or it will not be processed

Member's Name: _____	Patient's Name: _____
Member's ID Number: _____	Relationship: _____
BCBSNE Claim Number: _____	Date(s) of Service: _____
Provider Name: _____	Location of Services: _____
Individual NPI: _____	Clinic Tax ID or NPI: _____
Contact Name: _____	Address: _____
Phone Number: _____	Fax Number: _____

Appeal: A request to Blue Cross and Blue Shield of Nebraska when provider or member disagrees with a **denied** claim/ service, whether it is for preauthorization, medical necessity or another reason as described below based on the information presented.

If a claim has been *returned* a new claim must be submitted and *this form is not applicable*. If the denial is not listed below, the request may be considered a reconsideration and not an appeal; for reconsiderations, use the [Reconsideration Request form](#).

Reason for Appeal (mark applicable box):

- | | |
|--|---|
| <input type="checkbox"/> Denied Not Medically Necessary (attached) | <input type="checkbox"/> Denied No Preauthorization Obtained |
| <input type="checkbox"/> Denied Experimental/Investigative (attached) | <input type="checkbox"/> Contract Exclusion/Duplicate Service |
| <input type="checkbox"/> Medical Records Not Received (attached) | <input type="checkbox"/> High Dollar Prepayment Review |
| <input type="checkbox"/> Other - describe details in comment section below | |

Comments:

Please include any written comments, office notes, operative reports, or other relevant information for Blue Cross and Blue Shield of Nebraska to consider during their review.

Submit to:

NaviNet: Upload as one document on the Claim Status Details screen

Mail: Appeals Department, Blue Cross and Blue Shield of Nebraska, PO Box 3248, Omaha NE 68180-0001

Fax: 402-548-4684

For questions, please follow the process to check claim status via [NaviNet](#).