LOUISIANA BLUE

Medical Appeal Request Form

APPEAL REQUEST FOR NOT MEDICALLY NECESSARY/INVESTIGATIONAL DENIAL

To start this process, complete this form and submit it for review within 180 days of the date on your initial denial letter. Please submit this form with **your reason for appeal AND supporting documentation** to:

Blue Cross and Blue Shield of Louisiana Attn: Medical Appeals P.O. Box 98022 Baton Rouge, LA 70898-9022 Fax: (225) 298-1837	**Appeal Submitted By:** ☐ Member ☐ Healthcare Provider as Authorized Representative** ☐ Other Authorized Representative (Not a Provider)

MEMBER/PROVIDER INFORMATION

Member Name:	Provider Name:
Member ID #:	Provider Phone #:
Date of Birth:	Provider Fax #:
Service Being Appealed:	Provider Contact Name:
Reference Number (if available):	Date of Service:

SELECT APPEAL REQUEST TYPE

☐ **Standard Appeal-Member/Healthcare Provider as Authorized Representative**/Other Authorized Representative**

If you want someone to act on your behalf (**authorized representative**), please sign below and have your authorized representative return it to us **with any other documentation about your case**. We cannot consider an appeal request if we do not have your signature giving us permission to work with someone else.

Member Signature: _____ Date: _____

Healthcare Provider as Authorized Representative:

As the healthcare provider and authorized representative for the above-named member, I/we/it waive(s) any right to payment from the above-named member other than any applicable copay or other coinsurance amount based on the member's plan.**

Provider Signature: _____ Date: _____

Print Name: _____

Other Authorized Representative (Not a Healthcare Provider):

Print Name: _____

Address: _____

☐ **Expedited/Urgent Appeal** (This does not apply to care already provided) Explain why you believe the patient needs the requested service and why the response time for the standard appeal process (up to 30 days) will harm the patient:

_____

I certify, as the patient's treating physician, that delaying the patient's requested care for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health or ability to regain maximum function or subject the patient to severe pain that cannot be adequately managed without the requested care.

Physician (MD) Signature: _____ Date: _____

If an Urgent/Expedited appeal is submitted that does not meet the above criteria or does not have the physician attestation signature, the appeal will be processed as a standard appeal.