BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDER Grievance Form

(This is an OPTIONAL form.)

Send to: BCBSAZ, P.O. Box 13466, Phoenix, AZ, 85002

Date _____ Name of Provider _____Provider NPI # or Tax ID _____

Mailing
Address_____

City _____ State _____ ZIP Code _____

Contact Person _____Phone # _____

Member Name _____ Member ID # _____

Date(s) of Service _____ Claim # _____ Patient Account # _____

Plan or Account Name and Alpha Prefix

☐ **BCBSAZ** – Includes XBB, XBC, XBF, XBG, XBH, XBK, XBM, XBP, XBS, XBW, UHL*
Other group-specific alpha prefixes may be assigned to certain 1000+ groups. Refer to the BCBSAZ Alpha Prefix Grid on azblue.com for a listing of additional alpha prefixes. (* Level 1 appeals only.)

☐ **Federal Employee Program (FEP)** – Alpha prefix "R" followed by eight numeric characters.

☐ **BlueCard (Out-of-state)** – Note: The minimum three letter alpha prefix varies by Blue Plan. Please send all BlueCard grievances directly to BCBSAZ. BCBSAZ will handle disputes related to claims coding and pricing, and will forward all other disputes to the Home plan for resolution.

☐ **CHS** – **pricing related disputes only**. The TPA is responsible for handling all appeals from providers, and *any grievances from providers that are not pricing related*

Reason for Grievance – Please provide a detailed description of the issue and include appropriate documentation to support your position (medical records, operative report, etc.)

Please check appropriate box: ☐ Level 1 Grievance ☐ Level 2 Grievance

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