

Appeal and Grievance Quick Reference Guide for Providers



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Plan or Account Name	Alpha Prefix on ID Card	Appeal and Grievance Address and Mail stop Information
Blue Cross Blue Shield of Arizona (BCBSAZ)	<p>HMO: XBG, XBH, XBK PPO: XBB, XBM, XBP, UHL*</p> <p>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.</p> <p>*Level 1 appeals only</p> <p>Indemnity: XBC, XBF Medicare Supplements: XBS Dental only: XBW</p> <p>DentalChoice: The alpha prefix is the same prefix as on the member's medical ID card when DentalChoice is a benefit. (Generally, the word "DENTAL" appears on the ID card.)</p>	<p>Claims Issues: Level 1 Customer Service Claims Dept. Mail Stop N104 BCBSAZ P.O. Box 13466 Phoenix, AZ 85002</p> <p>Medical Issues: Level 1 Manager—Medical Appeals and Grievances Mail Stop A116 BCBSAZ P.O. Box 13466 Phoenix, AZ 85002 Fax: (602) 544-5601</p> <p>Claims and Medical Issues: Level 2 Grievances and Level 2 and 3 Appeals Medical Appeals and Grievances Coordinator Mail Stop A116 BCBSAZ P.O. Box 13466 Phoenix, AZ 85002 Fax: (602) 544-5601</p>
BlueCard: Out-of-state Blue Plans	<p>Minimum of three letter alpha prefix, but varies by state and Blue Plan.</p>	<p>Claim Issues: Level 1 and Level 2 Blue Card Host Claims Mail Stop E106 BCBSAZ P.O. Box 13466 Phoenix, AZ 85002 Fax: (602) 864-5120</p> <p>Note: 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.</p>
Federal Employee Program (FEP)	<p>R followed by eight numeric characters. (For both medical and dental plans).</p>	<p>FEP Claims and Medical Issues: Level 1 and Level 2 FEP Customer Service Mail Stop P105 BCBSAZ P.O. Box 13466 Phoenix, AZ 85002</p> <p>FEP Precertification Issues: Level 1 and Level 2 FEP Medical Review Mail Stop P102 P.O. Box 13466 Phoenix, AZ 85002 Fax: (602) 864-4664</p>
Corporate Health Service (CHS) Accounts	<p>No alpha prefix on ID card, but group number is required.</p>	<p>Note: For CHS claims, submit pricing related grievances directly to BCBSAZ and all other appeals and grievances directly to the TPA.</p>

Level 1 = 1st time issue is appealed
 Level 2 and 3 = Subsequent appeals

(See reverse side for additional information.)

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Reason for Appeal or Grievance and Documentation Required

Examples of Grievances	Documentation Required
<p>Grievances processed by the Claims Dept.</p> <ul style="list-style-type: none"> • COB issues • Coinsurance/deductible and sanction deductible • Fee schedule disputes • Timely filing <p>Grievances processed by the Medical Appeals and Grievance Dept.</p> <ul style="list-style-type: none"> • Outpatient global pricing • DRG payment • Fragmentation of incidental procedures • Modifiers • Multiple medical/surgical procedure processing • Mutually exclusive procedures • Procedure unbundling • Denials based on investigational or medical necessity determinations that require a provider write-off 	<ul style="list-style-type: none"> • Detailed explanation of issue or correction • BCBSAZ claim number • Copy of corrected claim, if applicable • Evidence of primary payer reimbursement (for COB issues) <p>Proof of claims filing and timeliness</p> <p>Paper claim: A copy of the computer screen-print showing date of submission to BCBSAZ.</p> <p>Electronic claim: A copy of the APN report showing receipt of the clean claim by BCBSAZ.</p> <p>For both claim types: Include dates of timely follow-up with BCBSAZ and the BCBSAZ contact name.</p>
Examples of Appeals Filed on Behalf of a Member	Documentation Required
<p>Appeals processed by the Medical Appeals and Grievance Dept.</p> <ul style="list-style-type: none"> • Assistant surgeon • Benefit plan limitations • Claims that deny for no precertification • Cosmetic procedures • Dental appeals • Eligibility (member) • Contract exclusions • Ineligible provider • Pre-existing conditions • Waived conditions • Investigational (member responsible) • Not medically or dentally necessary (member responsible) 	<ul style="list-style-type: none"> • Detailed explanation of issue • Must be accompanied by applicable medial records and/or operative report to support explanation (Please note: failure to submit supporting documentation may delay processing of your request.)

BCBSAZ timeframes to file Appeals and Grievances

Level 1 Claim Appeal: Should be filed within two years from initial denial. (FEP Appeals must be filed within one year.)

Level 2 Claim Appeal: Should be filed within 60 days of Level 1 determination.

Level 3 Claim Appeal: Should be filed within 30 days of Level 2 determination. (FEP is excluded from Level 3 appeals.)

Level 1 Grievance: Should be filed within one year of claim processed date.

Level 2 Grievance: Should be filed within 60 days of the Level 1 determination.

Timeframes for FEP, BlueCard and CHS accounts may vary.

Important reminders: Please include the member name, member ID, claim #, provider name, provider NPI #, contact person and phone number on all appeals. Send the appeal to the appropriate address and mail stop as indicated on the previous page; otherwise, delays in processing may occur.

The "Health Coverage Appeal Request Form" and "Provider Certification Form for Expedited Medical Review" are components of the BCBSAZ Health Coverage Appeals Packet. Although you may use these forms, the phone numbers referencing the Arizona Department of Insurance apply only to those products under the BCBSAZ Health Coverage Appeals Process.

This is a brief summary only and is not an all-inclusive list of the appeals processes available. Please refer to the appeal and grievance procedures outlined on our Web site at azblue.com, or in Section 13 of the *Provider Operating Guide* for a complete explanation of the BCBSAZ Appeal and Grievance process, including expedited appeals.

Health Coverage Appeal Request Form

You may use this form to tell BCBSAZ you want to appeal a denial decision.

Member Name _____ Member ID# _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____

Phone # _____

City _____ State _____ Zip Code _____

Type of Denial: Denied Claim Denied Service Not Yet Received

If you are appealing BCBSAZ's decision to deny a service you have not yet received, could a 30 to 60 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____

(Explain what you want BCBSAZ to authorize or pay for.)

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your Appeal, you may call the Arizona Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or BCBSAZ at (602) 864-4400 or (800) 232-2345.

Make sure to attach everything that shows why you believe BCBSAZ should cover your claim or authorize a service,

including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.)

**Also attach the certification from your treating provider if you are seeking expedited review.

Medical Appeals and Grievances Department – Mail Stop A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

Signature of insured or authorized representative _____ Date _____

Provider Certification Form for Expedited Medical Review



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(You and your provider may use this form when requesting an expedited appeal.)

Is the appeal for a service that the patient has already received? Yes No

If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.

If "No," continue with this form.

A patient who is denied authorization for a covered service not yet provided is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Provider Information

Treating Physician/Provider _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip Code _____

Patient Information

Member Name _____ Member ID# _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip Code _____

Insurer Information

Insurer Name _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip Code _____

What service denial is the patient appealing? _____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient.

Attach additional sheets if needed and include: Medical records Supporting documentation

If you have questions about the appeals process or need help to prepare your Appeal, you may call the Arizona Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or BCBSAZ at (602) 864-4400 or (800) 232-2345.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) 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 with the care of treatment that is the subject of the request.

Provider's Signature _____ Date _____