Excellus

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Provider Request for Grievance or Appeal

For Commercial and Safety Net products ONLY
Please mail this form and medical records/supporting documentation to:
Excellus BCBS Advocate Unit, PO Box 4717, Syracuse, NY 13221

Please use only black pen to complete this form. Other colors or highlighters may not show when documents are scanned. All information on this form is required to ensure timely processing.

Member and Provider Contact Information	
Member Name:_____ **Subscriber ID Number** (include prefix): _____ **Date of Birth** (MM/DD/YYYY): _____	**Provider Name**_____ **Contact Address**_____ **Phone**: _____ **Fax**: _____ **Email**: _____

Claim Information		
Provider Name:	**NPI**:	**Tax ID**:
Claim #:	**Claim Type:** ☐ CMS-1500/837P/Professional ☐ UB-04/837I/Facility	**Denial Date**
Date of Service: (MM/DD/YYYY)	**Authorization Number** (if applicable)**:**	**Procedure Code(s)**:

Please check one box to identify your Provider type			
☐ Ancillary – Participating Provider	☐ Ancillary – Non-Participating Provider	☐ MD/DO/Facility – Participating Provider	☐ MD/DO/Facility – Non-Participating Provider

If one of the following boxes applies to your inquiry, please check the appropriate box and fax form with all <u>supporting documentation</u> to 1-315-671-6656.		
☐ Cases (other than retrospective) in which an immediate review is required for an expedited situation.	☐ Denial of Continued or extended health care services	☐ Denial of Requests for additional services in a course of continued treatment

For all other inquiry types, please check the appropriate box and include all <u>supporting documentation</u>.			
☐ Benefit Dispute	☐ Clinical Editing (Dispute, Denied Inclusive, Mutually Exclusive, Procedure Modifier Disallow)	☐ Exceeded Units	☐ Lack of Authorization/Referral
☐ Not Medically Necessary Inpatient / Level Two Inpatient Appeal	☐ Pay Percentage Reduction	☐ Timely Filing	☐ If none of these apply, please check this box and describe your request in the comments below.

Comments: