

PROVIDER RESOLUTION FORM

By submitting this form, I understand that I am requesting review on my own behalf.

Use this form for adjudicated claims only!

Date:	
Member Name:	
Member ID Number:	
Provider Name:	Provider Telephone Number:
Provider ID Number:	
Specialty:	
Hospital Name:	
Date of Service:	Reason for Denial:
Procedure Codes:	Description:
Diagnosis Codes:	Description:
Type of Complaint:	
Records Attached: <input type="checkbox"/> Yes	
Records are required when using this form.	

Use this form for adjudicated claims/issues only.

BCBSNC Provider Inquiry Review
Attn: Provider Resolution
PO Box 2291
Durham, NC 27702-2291

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