MEDICARE NON-CONTRACT PROVIDER POST SERVICE APPEAL FORM

This form is intended for use only when a non-contract provider is requesting a review of a service that has been provided to a Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Medicare Advantage member and payment of a claim was denied.

Please submit any supporting documentation along with this form to: ***BlueCross BlueShield of North Carolina, Attn: Medicare Appeals and Grievances, P.O. Box 1291, Durham, NC 27702-1291. The Wavier of Liability form included in this document must be completed and submitted along with the appeal request.***

Section I: Patient Information

Subscriber ID		**Patient Date of Birth**
Patient First Name	**Middle Initial**	**Patient Last Name**

Section II: Physician Information

Requesting Physician (Print first name, last name)	**Physician NPI Number**	
Phone Number		**Fax Number**
Physical Mailing Address (Street or P.O. Box)	**City, State**	**Zip Code**

Section III: Appeal Information

Date of Service (Month, Day, Year)	**EOP Date of Notification of Denial** (Month, Day, Year)
CPT Codes	**Diagnosis Codes**
Claim Identification Number	
APPEAL REASON (Please state reason for appealing and attach any additional information you believe may help your case): Please use additional pages if necessary.	

WAIVER OF LIABILITY STATEMENT

PO Box 2291, Durham, NC 27702-2291

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Enrollee's Name _____

Enrollee ID Number _____

Provider _____

Dates of Service _____

Health Plan _____

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature _____

Date _____

Blue Cross and Blue Shield of North Carolina is an HMO and PPO plan with a Medicare contract.
Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
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