PROVIDER APPEAL – LEVEL 1 (POST-SERVICE ONLY)

This form is intended for use only when requesting a review of a post service claim denied for services not considered medically necessary or inpatient administrative denials.
Requests received without the required information below will not be reviewed.

Today's Date	**Member ID**	**Group Number**
Member First Name	**Member Last Name**	**Date of Birth**
Provider Name		**Provider NPI**
Provider Group Name		**Office Contact Name**
Mailing Address	**Phone Number**	**Fax Number**
Claim Number(s)	**Date(s) of Service**	
Inpatient Admission, CPT, or HCPCS Code Being Disputed		
Explanation of Request ***(use additional pages if needed)***		

REMINDERS

- DO NOT use this form if you are:
  - Appealing pre-service or pre-authorization decisions
  - Disputing coding/bundling denials
  - Submitting FEP or Blue Medicare appeals
  - Acting on behalf of a member
- If you are acting on the members' behalf this form will not be accepted. Please follow the member appeal process for appeal requests on behalf of the member as outlined at:
  https://www.bcbsnc.com/providers/forms-documents/member-appeal-representation-authorization-form
- Electronically submit post-service appeals via Blue e with supporting documentation and medical records:
  https://bluee.bcbsnc.com/providers/web/login
- Fax your request with all supporting documentation and medical records to:
  919-287-8709
- Mail your request with all supporting documentation and medical records to:
  Provider Appeal Department, P.O. Box 2291, Durham, NC 27702-2291

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