Empire BlueCross BlueShield

An Anthem Company

Claim payment appeal – submission form

This form should be completed by providers for payment appeals only.

Member information:

Member first/last name: _____ Member DOB: _____

Member coverage: □ Medicaid

Member ID: _____

Provider/provider representative information:

Provider first/last name: _____ NPI number: _____

Provider street address: _____

City: _____ State: _____ ZIP Code: _____

□ I am a participating provider. □ I am a nonparticipating provider.

Provider representative: □ Self □ Billing agency □ Law firm □ Other: _____

Representative contact name: _____ Contact phone: (_____) _____

Representative street address: _____ Email: _____

City: _____ State: _____ ZIP code: _____

Claim Information*:

Claim number: _____ Billed amount $_____ Amount received $_____

Start date of service: _____ End date of service: _____ Authorization number: _____

***If you have multiple claims related to the same issue,** you can use one form and attach a listing of the claims with each supporting document.

Payment appeal

A payment appeal is defined as a request from a health care provider to change a decision made by Empire BlueCross BlueShield HealthPlus (Empire) related to claim payment for services already provided. A provider payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

□ First-level appeal □ Second-level appeal

To ensure timely and accurate processing of your request, please complete the payment dispute section below by checking the applicable determination provided on the Empire determination letter or explanation of payment.

□ Untimely filing
□ No authorization
□ Denied for other health insurance (OHI), but member doesn't have OHI
□ Experimental/investigational procedure denial
□ Claim code editing denial
□ Retrospective authorization issue
□ Disagree that you were paid according to your contract
□ Data elements on the claim on file does not match the claim originally submitted
□ Denied as duplicate
□ Denial related to provider data issue
□ Member retro-eligibility issue
□ ER level of payment review
□ Other: _____

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Mail this form, a listing of claims (if applicable) and supporting documentation to:

Payment Appeals
Empire BlueCross BlueShield HealthPlus
P.O. Box 61599
Virginia Beach, VA 23466-1599

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.