BlueChoice® HealthPlan
South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

PHYSICIAN APPEAL/RECONSIDERATION REQUEST FORM

Please fax this completed form along with all pertinent clinical documentation to BlueChoice HealthPlan at 800-610-5685.

Your Name: ______________________________

Practice's Name: ______________________________

Practice's Phone: ____________________ **Practice's Fax:** ____________________

Total number of pages in fax including cover page: ____________

Please tell us about the patient and the appeal.

Patient's Name: ______________________________

BlueChoice HealthPlan ID#: ____________________ Date of Birth: ____________

Involved Physicians: ____________________ Tax ID: ____________

Date of Services: ______________________________

Claim Number or Reference Number: ____________________

Explain the issue and reason for review request:

Signature: ____________________ Date: ____________

Office Phone Number and Extension: ______________________________

Office Fax Number for Acknowledgement Letter: ______________________________

Fax this form to BlueChoice HealthPlan at 800-610-5685.

FILE APPEALS WITHIN 90 CALENDAR DAYS OF THE ORIGINAL CLAIM PROCESSING DATE.

(Rev. 1/10)