BlueCross BlueShield of New Mexico

Provider Request for Appeal on Behalf of Member

For timely processing of your request, please attach the following information:

1. Copy of the Explanation of Benefits/Remittance Advice and/or denial letter
2. Any additional information to support your request (i.e., medical records, etc.)

Mail completed form and any applicable documents to the attention of the Appeals Department, P.O. Box 27630, Albuquerque, New Mexico 87125-7630.

Note: *Member or patient must sign at the bottom of this form designating assignment of representation.*

Please complete:

Employee/Cardholder Name: _____

Current Address: _____

Phone Number: _____

Date(s) of Service: _____

BCBSNM Identification Number: _____ Group Number _____

Patient Name: _____

Provider(s) Name(s): _____

Provider NPI Number(s) _____

Provider's reasons for this request (attach additional pages if necessary):

_____

_____

_____

The following documents to support this request are enclosed:

_____

_____

_____

Signature of Requestor: _____ Date of Request: _____

I (the Member or Patient) ***authorize*** _____ (the Provider) ***to represent me in the Appeal process regarding the above services.***

Member/Patient Signature: _____ Date: _____

If Patient is under the age of 18, the signature of the Member is required.

Rev 03/24/14