BlueCross BlueShield of North Carolina
MEDICARE

Instructions for Completing Medicare Advantage Provider Appeal Form

Do not use for Federal Employee Program (FEP) or Commercial

Blue Cross NC providers must use the revised appeal form for Provider Appeals to be accepted for Medicare Advantage products. The form should be completed in its entirety to be considered valid for review. All fields (unless noted *if applicable* or *optional*) should be completed. If the form is not completed properly and, in its entirety, the appeal will be deemed invalid for review.

All North Carolina providers should use this form to submit provider appeal requests on their own behalf. Blue Cross NC is responsible for resolving provider appeal coding/bundling claim denials for both Medicare Advantage and Blue Card policies. Please note: Medical necessity denial appeals are only for Medicare Advantage policies.

Please follow the detail below for the following specific fields:

- **Provider Name** – Please ensure that the provider listed on the form matches the provider on the claim being appealed. Please note, a referring or ordering provider cannot appeal the denial of another provider's claim.
- **Office Contact** – Please provide the name of the person that can be contacted directly for questions on this appeal.
- **Contact Fax Number** – Please provide a valid return fax number where correspondence regarding this appeal and the final decision can be sent. This will also assist in obtaining any additional records during the appeal review process.
- **Inpatient Admission/CPT/HCPCS Code of Service Being Disputed** – Must have either a CPT, revenue code or *Inpatient Admission* listed.
- **Explanation of Your Request** – Appropriate to state *see attached* but cannot be left blank.

Providers can submit a provider appeal on their own behalf for the following claim denials:

- Billing and Coding Disputes:
  - Integral Part of Primary Service
  - Mutually Exclusive
  - Services Not Eligible for Separate Reimbursement
  - Incidental Denial
  - Surgical Global Period Denial
  - Re-bundling

- Medical Necessity ***(Post Service Claim Denials Only)***:
  - Not Medically Necessary
  - Cosmetic Services
  - Investigational/Experimental Services
  - No Authorization for Inpatient Hospital Admission
  - Inpatient vs Observation Admission

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Providers may not appeal any issues that are considered member benefit or contractual issues. Examples of reviews not eligible for the provider to appeal on their own behalf are:

- Deductible/coinsurance issues
- Benefit limitations
- Benefit Exclusions/Non-Covered Services
- Membership Issues
- Corrected Claim/Claim Mail back – these should be sent directly to claims
- Requests for additional payment above UCR
- Administrative prior authorization denial for place of service other than inpatient

It is the responsibility of the provider's office that performed the service in question on a denied claim to appeal if the above criteria are met. When submitting a provider appeal, it is important to include all supporting documentation at the time the appeal is submitted. This includes pertinent medical records to support the denial in question for the date of service on the claim. This allows a more timely review of the appeal.

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