



BlueCross BlueShield
of New Mexico

Appeal Request Form

Patient Information

Patient Name _____
Member Identification Number _____
Group Name and Number _____

Case Information

Date(s) of Service (Service from Date and Service to Date) _____
Place of Service (Facility Name) _____
Case Number (if applicable) _____
Date Service/Procedure(s) non-allowed (Service Actual End Date) _____

Physician/Facility/Provider Information

Physician Name (Attending Provider Full Name) _____
Facility or Provider Name _____

Appellant Information

Name of individual submitting appeal _____
Signature _____
Telephone Number _____
Today's Date _____
Reason for Request _____

If the member is not requesting this appeal, you must have the member's signature to authorize you as their representative.

Member Signature _____

Attach additional information, Explanation of Benefits, Notification Letter and/or medical records for the dates of service being appealed and submit to: