



**Blue Cross and Blue Shield  
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 (EOB)/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,  
PO 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: \_\_\_\_\_

BCBSNM Group/Enrollment 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.*