



Blue Cross and Blue Shield
of New Mexico

Provider Request for Claim Review

Provider's Name: _____
Contact person in provider's office: _____
Provider's phone number: (_____) _____

Patient name: _____
Patient ID number: _____

REASON FOR REVIEW:

Corrected Claims
Description of correction:

Timely Filing
(Proof must be attached)

Other
(Please list reason for review – Examples: Pricing, Medical, Bundling/ClaimCheck®, Modifier Issues)

Instructions for completion of Provider Request for Claim Review form:

- All claim appeal requests **MUST** be submitted on this form.
- Attach relevant claims, Provider Claims Summaries (PCS), correspondence and any additional information you feel is pertinent to the appeal review.
- If attaching a corrected claim or any other correspondence, always place the Provider Request for Claim Review form on top.
- Specify the "Reason for Review" on the form. If you do not specify, your issue may not get resolved.
- This form may be photocopied on **WHITE** paper for future use. **DO NOT** submit any Provider Request for Claim Review forms on **COLORED** paper, as colored paper does not scan well and may cause items to be illegible.
- For further information, consult the *Blues Provider Reference Manual*, which can be found on our Web site at www.bcbsnm.com.
- If you have any questions, please contact the BCBSNM Provider Service Unit (PSU) at 1-888-349-3706.
- Mail your completed Provider Request for Claim Review and any support materials to:

Blue Cross and Blue Shield of New Mexico
ATTN: Mail Services
 P.O. Box 27630
 Albuquerque, NM 87125-7630