FYI:
CAT

CATASTROPHIC PETITION REQUEST

Hospital Name:_____

Patient Name:_____

Certificate Number: _____ **Group Number:** _____

Claim Number:_____

Date of Admission:_____ **Date Mailed:**_____

Contact Name/Number:_____

Instructions:

Please complete the section above with the appropriate facility and claim information requested and forward this form with the elements of the patient's medical record listed below to the following address:

Blue Cross and Blue Shield of New Mexico
Attn: Catastrophic Review Department
PO Box 660044
Dallas, TX 75266-0044

Required Medical Record Element Checklist:

- ☐ **Completed Original Print of UB-04**
- ☐ **Itemized Statement of Charges for Entire Stay**
- ☐ **History and Physical**
- ☐ **Admit and Discharge Summary**
- ☐ **MD Orders**
- ☐ **Progress Notes**
- ☐ **Emergency Room Records if indicated**
- ☐ **Operative Notes if indicated**
- ☐ **Implant Invoices if indicated**

If additional documents are required they will be requested

Comments:_____

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Sept. 26, 2019