BlueCross BlueShield of New Mexico

Provider Request for Appeal on Behalf of a Medicaid 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:
Turquoise Care (Medicaid) Appeals Department, P.O. Box 660717, Dallas, TX 75266-0717 Or fax to: 888-240-3004; Attention: Appeals & Grievances.

Note: ***Member or patient must sign at the bottom of this form authorizing assignment of representation.***

Please complete:

Member/Patient Name: _____

BCBSNM Identification Number: _____ Group Number: _____

Name of the Requestor: _____ Date: _____

Current Mailing Address: _____

Phone Number: _____

Date(s) of Service: _____

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:

_____

_____

_____

I (the patient or parent/guardian) ***authorize*** (the requestor): _____
to represent me in the appeal process regarding the above services.

Member/Patient Signature: _____ Date: _____

Note: *If patient is under the age of 18, the signature of the parent/guardian is required.*