Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence Provider Appeal Form

Special Message: Please note contracted providers are to dispute a claim on Availity from the claim status results page. From the Availity home screen menu select Claims & Payments >Claim Status. Additional training may be accessed through Availity demo, Claim status page. If you do not have the ability to submit via Availity please contact Provider Customer Service.

Use the appeal form to disagree with our decision that:

- Pre-authorization was not obtained
- No admission notification was provided
- Claim denied for not meeting our medical necessity criteria
- National Correct Coding Initiative (NCCI) or Correct Coding Editor (CCE) coding rules apply to a claim or claim line
- Claim denied as a duplicate when services were performed more than one time, and **payment does not reflect multiple service payment**
- Appeals regarding reimbursement amounts paid for unlisted procedure codes
- Appeals regarding denial of additional reimbursement for the use of a payment enhancing modifier (modifier -22)

Do not use this form if your request is not related to one of the reasons listed above. **Contracted providers submitting pricing disputes must use the Pricing Dispute Form located on the provider website**. Please review the information about all other appeals on our provider website at **regence.com**: Claims and Payment>Receiving Payment>Appeals. The form is also available in the Library section under Forms.

Fields marked with an asterisk (*) are required fields.

Providers that are unable to submit an Availity Appeal, may fax completed form to: 1 (866) 273-1820.

Please enter your contact information for this change request		
Name*		
Organization or Provider Name(s)*		
E-mail* Email address	Phone Number* (xxx) xxx-xxxx	Fax Number* (xxx) xxx-xxxx
NPI Number*	Tax ID Number*	

Enter information about the claim to be appealed		
Has (have) this claim(s) been appealed to Regence before?* ☐ Yes - *please supply a copy of the appeal determination letter* ☐ No		
Regence Claim Number(s)*		
List the specific CPT/HCPCS you are appealing*		
Date(s) of Service*		
Member ID Number (prefix/member ID)*		
Patient Name*	Patient Date of Birth* (mm/dd/yyyy)	Total Billed Amount*

This section applies to denials for Pre-authorization not obtained or no admission notification provided

Why was the pre-authorization not submitted or the admission notification not provided? (Select one): With: Below outlines the approved exception reasons for not obtaining pre-authorization or providing admission notification. You must indicate in your dispute and provide evidence for which exception criteria you meet. Helpful Tip: The Appeals page on the provider website lists suggested documentation that may help support your dispute.

- Member presented with an incorrect member card or member number.
- Natural disaster prevented the provider or facility from securing a pre-authorization or providing hospital admission notification.
- Member is unable to communicate (e.g., in a coma) medical insurance coverage. Neither family nor collateral support present is able to provide coverage information.
- Compelling evidence the provider or facility attempted to obtain pre-authorization or provide hospital admission notification. The evidence shall support the provider or facility followed Regence policy.
- Notification was given, or pre-authorization was obtained, however the claim was denied.
- A participating provider or facility is unable to anticipate the need for a pre-authorization before or while performing a service or surgery.
- An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to delivery of the service. *NOTE: This applies only to plans issued on or after January 1, 2018 by Regence in WA State excluding Medicare Advantage and FEP.

Summarize your description of why your denial should be overturned. Describe your reasons in detail so we can make an informed decision. Your evidence must support that you followed Regence policy.

This section applies to requests for appeal when:

- NCCI or CCE coding rules apply to a claim or claim line.
- A claim denied as a duplicate when services were performed more than one time, and **payment does not reflect multiple service payment**.
- Payment dispute for unlisted or increased procedural service (Modifier 22).
- Services denied as not medically necessary.

Please tell us about your dispute, provide detailed explanation and desired outcome (include the specific CPT/HCPCS):

Substantiate your request with documentation for all dates of service you are disputing, and **include documentation with this form.**

Examples of documentation include, but are not limited to:

- Chart notes
- Operative report(s)
- AMA-related article(s)