BlueCross BlueShield of Illinois

Provider Service Authorization Dispute Resolution Request

This form should be used to dispute a service authorization denial or a reduction, suspension, or termination of a previously authorized service. This form is NOT to be used for claim/billing issues or disputes.

For claim/billing issues or disputes, please use the following link:
https://www.bcbsil.com/pdf/network/medicaid_claims_inquiry_dispute_request_form.pdf*

*Please note: Timely filing for a service authorization disputes is 60 days from the date of the disputed denial or claim notification.

PROVIDER INFORMATION		
PROVIDER NAME	NATIONAL PROVIDER IDENTIFIER (NPI)	
STREET ADDRESS		
CITY	STATE	ZIP
CONTACT PERSON FOR DISPUTE FOLLOW UP	PHONE	

MEMBER INFORMATION (A separate form must be completed for each member)		
MEMBER NAME		
DATE OF BIRTH	MEMBER ID	
AUTHORIZATION NUMBER	SERVICE DATE FROM	TO

REASON FOR DISPUTE (A detailed explanation must be provided)

- ☐ INCORRECT CRITERIA/MEDICAL POLICY UTILIZED
- ☐ GOOD CAUSE FOR FAILURE TO OBTAIN AUTHORIZATION (PLEASE SPECIFY)
- ☐ INCORRECT INFORMATION PROVIDED BY MCO
- ☐ MEMBER ELIGIBILITY CONCERN
- ☐ OTHER (PLEASE SPECIFY)

TO SUBMIT BY MAIL	**Blue Cross Community Health Plan** **Provider Authorization Disputes** **PO Box 660906** **Dallas, TX 75266**	TO SUBMIT BY FAX	**312-653-9443**

Important reminders: Attach additional supporting information for your dispute. If clinical information is not submitted with the dispute form, your request will not be accepted. The processing time for provider service dispute resolution requests is 30 calendar days from receipt of the request.