Request for Reconsideration of a Denied or Retracted Coordination of Benefits Claim
When the Other Carrier Information is Unclear

(Incomplete membership application, COB listed on prior claim, etc.)

You will have 60 calendar days from the receipt of our denial or retraction notice to make reasonable efforts, including at least one attempt to contact the member, to confirm existence of other insurance coverage. In addition, you will have another 30 calendar days to resubmit the claim, along with documents evidencing your efforts to determine the primary carrier, to Excellus BlueCross BlueShield for reconsideration.

Please provide us with the following information if you were unable to reach the member to confirm other insurance.

**Incomplete forms will be returned.**

<table>
<thead>
<tr>
<th>Request Date:</th>
<th>Provider Name:</th>
<th>Provider NPI or Tax ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Name:</td>
<td>Subscriber ID Number: (include prefix and suffix)</td>
<td>Patient Name:</td>
</tr>
<tr>
<td>Date of Service:</td>
<td>Claim Number:</td>
<td>Patient Acct. #:</td>
</tr>
</tbody>
</table>

Provider Office Contact Name and Address, Phone Number and/or E-mail Address:

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For each claim denied, we will require the following information:

<table>
<thead>
<tr>
<th>Date of attempt to contact member:</th>
<th>Name of member you attempted to contact:</th>
<th>How the contact was made: (include phone #)</th>
</tr>
</thead>
</table>

Result of the contact:

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If you have any questions about this form or have additional COB information for our records, please call Provider Service.

Please submit this form via: e-mail to: CNY.EformAdj@Excellus.com – or – mail to:
Excellus BlueCross BlueShield
PO Box 21146
Eagan, MN 55121

Form: RCOB Rev. 10/17