Quick Tips for Using Correct Forms



The *View Forms and Documents* section of our website contains forms to assist you in your day-to-day business with us.

There are times you may be uncertain of which form to use. This tip sheet is designed to explain the use of our most commonly accessed forms.

When submitting forms:

- Always include member information (name, ID number, date of service, claim number).
- Always include a new claim form if the information is changing from the original submission.
- Always use black ink and check to ensure that your writing is legible.
- Always submit all supporting information to streamline the review process.
- If you're mailing the form and supporting materials, please mail to the address listed on the form.

Questions?

- Contact Customer Care at 1-800-920-8889.

Form Name and Link	Category	Reason(s) for Use
Request for Grievance or Appeal	Benefits Management	▪ Request for grievance: a contractual denial or dispute of payment ▪ Request for appeal: An appeal is a denial for pre or post services. It is a denial that involves not medically necessary or experimental/investigational **Note:** For Medicare Advantage members, please refer to Section 9.8 of the Participating Provider Manual (login required). **Please attach medical records and any other pertinent information related to the grievance or appeal to this form**
APC Pricing Dispute Form	Billing and Remittance	▪ Disagreement with a claim that paid using ambulatory payment classification (APC) pricing **Must include detailed pricing expectation sheet for each line item**

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Form Name and Link	Category	Reason(s) for Use
APG Pricing Dispute Form	Billing and Remittance	▪ Disagreement with a claim that paid using ambulatory patient group (APG) pricing **Must include detailed pricing expectation sheet for each line item**
Claim Adjustment or Retraction Request Form	Billing and Remittance	▪ Additional information was requested on remit ▪ Correcting an original claim (attach new claim) Note: correction of a member ID does not require this form ▪ Member eligibility updated after denial ▪ Coordination of Benefit (COB) change affecting processing ▪ Incorrect benefits applied ▪ Incorrect denial ▪ Incorrect provider paid ▪ Incorrect payment ▪ Retraction requests when a check has been cashed
DRG Review Request Form	Billing and Remittance	▪ Disagreement with a claim that paid using Diagnosis Related Group (DRG) pricing **Must include DRG calculation sheet** (required)
Request for Out-of-Area Member Claim Appeal (BlueCard)	Billing and Remittance	▪ BlueCard® claim denied "not medically necessary" ▪ BlueCard claim denied "experimental/investigative" **Attach a letter of appeal with supporting documentation** Prior to submitting, please verify with the Home Plan if a signed authorization from the member is required.
Request for Timely Filing Review	Billing and Remittance	▪ Request for consideration of delayed submission **Provide supporting documentation**
Clinical Editing Review Request Form	Clinical Editing	▪ Bundled ▪ Incidental ▪ Mutually exclusive ▪ Daily max met ▪ Modifier 51 or 59 ▪ Correct coding initiative (CCI) denial ▪ Invalid procedure code ▪ Invalid modifier for procedure code **Attach remit and documentation** (required)