BlueCross BlueShield of Texas

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:

- Primary insurance EOB
- Invoice/MSRP
- Itemized bill (when required)
- Unlisted procedure code/ procedure code documentation
- Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- Claim was denied for no authorization, but authorization number _____ was obtained.
- Claim was denied due to lack of Texas Provider Medicaid enrollment. The TPI is: _____
- Claim was not paid per contracted rate with BCBSTX. My contracted rate with BCBSTX is _____ the terms of my contract with BCBSTX Plans. Please explain and advise of your payment expectation/amount:

  _____

  _____
- Claim was denied due to member ineligible however, member was effective for date of service rendered ____

  _____

  _____
- Other. Please explain.

  _____

  _____

  _____
- ☒ **Check box if this Reconsideration Request is for multiple claims.** Please attach a separate list if more than one claim number and/or member ID is related to this reconsideration request.

Provider Name	Provider Tax ID
Provider NPI	Original Payment Received
BCBSTX Claim Number*	Dates of Service*
Member Name*	Member ID*

Email completed forms and all attachments to:

Blue Cross and Blue Shield of Texas
Claims Reconsiderations
Texas Medicaid Network Department
Email:TexasMedicaidNetworkDepartment@bcbstx.com.

Contact name & number of person responsible for reconsideration _____ ___

BCBSTX