BlueCross BlueShield of Texas

Durable Medical Equipment (DME) Review Request Form

- Please complete one form per member to request a review of an adjudicated/paid claim.
- Fields with an asterisk (*) are required.
- Be specific when completing the "Description of Review" and "Expected Outcome."
- Please provider all **supporting documents** with submitted review.
- Review must be submitted **within 120 days of the remittance date.**
- Please email DME Review Request Form to:
  TexasMedicaidNetworkDepartment@bcbstx.com
  Or call the Medicaid Network Department at 1-855-212-1615

Line of Business Type*:(Check One): ☐ CHIP ☐ STAR ☐ STAR Kids

Provider Name*: _____

National Provider Identifier (NPI) Number*: _____ Tax ID Number*: _____

Street Address*: _____

City*: _____ State*: _____ ZIP code*: _____

CLAIM INFORMATION

Member Name*: _____ Date of Birth*: _____

Subscriber ID Number or Medicaid ID*: _____

Original Claim ID Number(s)/Corrected Claim ID Number(s): _____

Service "From/To" Dates* (dates of services): _____ / _____

Original Claim Amount Billed*: _____ Original Claim Amount Paid*: _____

Review Reason*: ☐ Eligibility ☐ Coordination of Benefits ☐ Authorization ☐ Claim Payment Incorrectly ☐ Timely Filing
☐ Medical Necessity ☐ Other

_____

_____

_____

_____

_____

Expected Outcome*: _____

_____

_____

_____

Contact Name (please print) *: _____ Title: _____

Phone Number*: _____ Fax Number: _____

Signature*: _____ Date*: _____

☐ Check here if medical records are attached.

☐ Check here if additional information is attached.