Louisiana

Provider Dispute Form

Complete this form to file a provider dispute. This form must be included with your request to ensure that it is routed to the appropriate area of the company, thus avoiding delays in our review process. It is important to include the proper information (based on your reason for review) and submit it to the appropriate mailing address.

Please submit only one form per patient, per dispute.

PROVIDER INFORMATION

TYPE OF PROVIDER: ☐ Professional ☐ Facility ☐ Other:	
Provider Name	
National Provider Identifier (NPI)	Provider Tax ID
Name of Person Completing Form	Date Form Completed
Contact Email Address	Contact Phone Number

PATIENT INFORMATION

Member ID	Policyholder Name	
Patient Name	Patient Date of Birth	
Claim Number	Date(s) of Service	Amount Charged

DISPUTE DETAILS

To assist us in reviewing your dispute, please summarize the issue and action desired, and attach all supporting documentation.

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GUIDE FOR SUBMITTING SUPPORTING DOCUMENTATION

SURGERY, ASSISTANT SURGERY OR ANESTHESIA	DOCTOR'S HOSPITAL VISITS	DOCTOR'S OFFICE/CLINIC VISITS	OTHER SERVICE X-RAYS, LAB, PHYSICAL THERAPY
1. Operative Report 2. Anesthesia Report 3. Pre-op History and Physical 4. Asst. Surgeon Credential (If not M.D.)	1. Discharge Summary 2. Hospital Progress Notes 3. History and Physical Notes 4. Pathology Report	1. Office Notes Pertaining to Date of Service 2. History and Physical Notes	1. Physical Therapy Notes and Radiology/Lab Report

Page 2 of this form contains the list of reasons for your dispute. Please check only one reason per form. In order for us to review your dispute, we must receive the entire form.

A printable PDF of this form is available online at www.BCBSLA.com/providers, then click on the "Resources" section and look under Forms.

PLEASE REVIEW MY DISPUTE FOR THE FOLLOWING REASON

Check only one reason per form.

	REASON FOR REVIEW	SUGGESTED SUPPORTING DOCUMENTATION	TIME TO ALLOW RESPONSE FROM BCBSLA FROM DATE SUBMITTED	WHERE TO SEND
☐	Claim rejected as duplicate	• Supporting medical documentation	30 days	HARDCOPY: BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
☐	Claim denied for medical records	• Copy of our letter of request for medical records • Supporting medical documentation	30 days	HARDCOPY: BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
☐	Claim payment/denial affects the provider's reimbursement • Timely filing • Reimbursement • Authorization penalty • Bundling issue	• Provider Dispute Form including reason for dispute; if bundling issue, reason why current bundling logic is incorrect, or if reimbursement issue, expected allowable amount • Supporting medical documentation • Proof of timely filing (only if denied for timely filing)	60 days	HARDCOPY: BCBSLA - Provider Disputes P.O. Box 98021 Baton Rouge, LA 70898-9021 or FAX: (225) 298-7035 ELECTRONICALLY: Through iLinkBlue (www.BCBSLA.com/iLinkBlue), click "Document Upload," then "Provider Disputes" in the drop-down menu.
☐	Claim denied for a BlueCard® member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)	• Provider Dispute Form including reason • Supporting medical documentation	60 days	HARDCOPY: BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9045 or FAX: (225) 297-2727

FOR MEDICAL OR ADMINISTRATIVE APPEALS

If you need to submit a medical appeal, administrative appeal or grievance on behalf of a member, then you should instead complete the Medical Appeals Request Form or the Administrative Appeal Request Form. Both are available online at www.BCBSLA.com/forms-and-tools under Appeals and Claims Forms.