PROVIDER GRIEVANCE FORM

(This is an OPTIONAL form.)

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

When a provider disagrees with a payment of a claim, or wishes to grieve a nonpayment issue, the provider may initiate the Provider Grievance Process. For more information, see azblue.com/ProviderDisputes.

Complete form and send with all-inclusive documentation to:

BCBSAZ Appeals and Grievances Department - Mailstop A116
P.O. Box 13466
Phoenix, AZ 85002-3466

Provider Information			
Date (mm/dd/yyyy) / /	Provider Name		
NPI #	Tax ID #		
Mailing Address			
City	State	ZIP Code	
Contact Person	Phone #		

Member Information ***(if applicable, you may add more than one claim for this member)***		
Member Name	Member ID #	
Date(s) of Service (mm/dd/yyyy) / /	Claim #	Patient Account #
Add additional claims for this member if applicable.		
Date(s) of Service (mm/dd/yyyy) / /	Claim #	Patient Account #
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Reason for Grievance
Please provide a detailed description of the issue related to each claim indicated above. If there are additional claims related to this member, please list them here. Attach to this form all-inclusive documentation to support your position (medical records, operative report, etc.)

Check appropriate box: ☐ First-level Grievance *(initial request)* ☐ Second-level Grievance

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