RESET

Horizon Blue Cross Blue Shield of New Jersey

POST SERVICE MEDICAL NECESSITY APPEAL REQUEST

To help us efficiently review your appeal, please submit this completed form along with all pertinent documentation to help support your appeal.

- The relevant CMS 1500(s) or UB04(s).
- The relevant Explanation(s) of Benefits, Remittance Advice or letter indicating the claim denial.
- Information previously requested that you have not yet submitted, if available.
- Pertinent correspondence related to this matter.
- A description of pertinent communications on this matter that was not in writing.
- Relevant sections of the National Correct Coding Initiative (CCI) or other coding support you relied upon if the appeal concerns the disposition of billing codes.
- Other documents (doctor's letter, medical records/notes, etc.) that help support your position in this appeal.

This completed form and all applicable supporting documentation may be:

Faxed to: **1-732-938-1417**

Or mailed to: **Horizon BCBSNJ**
Claim Policy Appeals, PP-09E
PO Box 220
Newark, NJ 07101-0420

Information about Claim being appealed

Patient Name: _____ Patient DOB: ___ / ___ / ___

Subscriber Name: _____ Subscriber ID #: _____

Claim #: _____ Date of Service: ___ / ___ / ___

Appeal being requested:
- ☐ First level appeal
- ☐ Second level appeal

Details of Appeal Request:

Information of person filing appeal*

*If the person filing this appeal is not the patient, consent may be required prior to processing this appeal request.

Name: _____

Address: _____

Phone: _____ Email: _____

Relationship to patient:
- ☐ Self
- ☐ Subscriber*
- ☐ Authorized Representative*
- ☐ Provider/Office Staff*

Signature _____ Date ___ / ___ / ___