



Out-of-Network Provider Negotiation Request Form

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Completing this form allows NJ physicians, hospitals, or other health care providers that **DO NOT PARTICIPATE** with Horizon BCBSNJ to initiate negotiation for the reimbursement of claims for services provided to Horizon BCBSNJ members in compliance with the NJ [Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act](#).

Mail completed forms to: **Horizon BCBSNJ
PO Box 106
Newark NJ 07101**

- Please submit a separate form for each negotiation request.
- Please do not submit new claims with this form.
- Please do not use this form to submit appeals or inquiries.

Or email to: OONSurpriseBill@horizonblue.com

Subscriber/Patient Information

Subscriber's Name _____

Subscriber's Horizon BCBSNJ ID # _____
Include Prefix

Patient's Name _____

Patient's Date of Birth _____ MM/DD/YYYY Patient Account # _____

Date of Service/Admission _____ MM/DD/YYYY Last Date of Service/Discharge _____ MM/DD/YYYY

Horizon BCBSNJ Claim # _____

EOP Denial Reason/Message Codes _____
Please list all Denial Reason/Message Codes included in the last column of your Horizon BCBSNJ Explanation of Payment (e.g., G807, Z084a, Z464, etc.).

Nonparticipating Provider Information

Physician Hospital Other Health Care Professional (Lab, etc.) Ancillary Facility (SNF, etc.)

Provider Name _____

NPI # _____ Tax ID# _____

Address _____

City _____ State _____ ZIP _____

Contact Name: _____ Contact Email _____

Contact Phone _____ Contact Fax _____

Request Submission Date _____
MM/DD/YYYY

Comments