BlueCross BlueShield Minnesota

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NON-MINNESOTA / NON-PAR PROVIDER CLAIM ADJUSTMENT / APPEAL FORM

One form per request or appeal

Today's Date: _____

Contact Person: _____ Phone: _____ Fax: _____

BCBSMN Tax ID or Provider ID: _____ NPI: _____

Provider Name: _____ Provider Return Address: _____

BCBS Member ID#:	Patient Name:	Claim #:
☐ Blue Card Plan Code:	Patient Account:	Enter remark code:
Group #:	Charge for service in question:	Service Date(s) in question:
☐ **Claim Adjustment Request**	A claim adjustment request is based upon a correction and/or new information for a previously processed claim. Adjustment requests are not appeals. We cannot adjust claims to deviate from contract benefits.	

Comments: _____

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☐ **Other Carrier Paid (include EOB – Explanation of Benefits)**

☐ Medicare (include EOMB)

☐ Worker's Compensation

☐ No-Fault auto insurance

☐ Other _____

☐ **Appeal** (Attach supporting documentation – Please refer to the Provider Policy and Procedure Manual for instructions)	An appeal is a request for reconsideration of a previously processed service (denial, payment reduction, coverage termination, etc.)

Comments: _____

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Website: https://www.bluecrossmn.com
Click on 'For the Health Care Providers' for the Provider Policy & Procedure Manual, Forms: Other
MN Statute 62J.536 requires Minnesota providers to submit adjustment/replacement/Cancel claims electronically using the HIPPAA 837P or 8371 transaction.

Mail to:
Blue Cross and Blue Shield of Minnesota
Attn: (Please indicate) Appeals or Claims Adjustments
PO Box 982800
El Paso, TX 79998-2800

Fax to: 651-662-2745
Attn: (Please indicate) Appeals or Claims Adjustments