Provider Feedback Form for Third-Party Clinical Policies/Guidelines/Criteria

All fields are required.

BlueCross BlueShield Minnesota

Provider Information		
First Name:	Last Name:	
Phone Number:	Email Address:	Provider Number (NPI):

Policy Information	
Policy Name	
Policy Number (if applicable)	
Policy Source: ☐ eviCore Healthcare Clinical Guidelines ☐ MCG Care Guidelines ☐ Prime Therapeutics (Pharmacy)	Line of Business: ☐ Commercial ☐ Medicaid ☐ Medicare
Comments:	
Supporting evidence submitted with this form:	

Please submit this completed form with all supporting documentation (e.g., published peer-reviewed scientific literature) by email to policy.provider.feedback@bluecrossmn.com.