BlueCross BlueShield of Texas

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

This form is for Texas Medicaid lines of business only. Any inquiries about other BCBSTX lines of business will not be processed.

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:

- Primary insurance EOB
- Invoice/MSRP
- Itemized bill (when required)
- Unlisted procedure code/ procedure code documentation
- Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- Claim was denied for no authorization, but authorization number _____ was obtained.
- Claim was denied due to lack of Texas Provider Medicaid enrollment. The TPI is: _____
- Claim was not paid per contracted rate with BCBSTX. My contracted rate with BCBSTX is _____ the terms of my contract with BCBSTX Plans. Please explain and advise of your payment expectation/amount:

  _____

  _____
- Claim was denied due to member ineligible however, member was effective for date of service rendered ____

  _____

  _____
- Other. Please explain.

  _____

  _____

  _____
- ☒ **Check box if this Reconsideration Request is for multiple claims.** Please attach a separate list if more than one claim number and/or member ID is related to this reconsideration request.

Provider Name	Provider Tax ID
Provider NPI	Original Payment Received
BCBSTX Claim Number*	Dates of Service*
Member Name*	Member ID*

Email completed forms and all attachments to:

Blue Cross and Blue Shield of Texas
Claims Reconsiderations
Texas Medicaid Network Department
Email:TexasMedicaidNetworkDepartment@bcbstx.com.

Contact name & number of person responsible for reconsideration _____ ___

BCBSTX