Appeal Form Instructions

ND

NOTE: The appeal form must be completed in its entirety. An incomplete form will be denied as an invalid appeal request.

Member Instructions

1. Complete Sections A and D of this form
2. Include or attach any additional information you think will help a favorable decision to be made on your adverse determination.

   If you need assistance completing this form, please call the number on the back of your member ID card.

3. Return completed forms by:
   - Fax: (701) 277-2209
   - Mail: Blue Cross Blue Shield of North Dakota
     PO Box 1570
     Fargo, ND 58107-1570

Authorized Representative Instructions

1. Complete Sections A, B, and D of this form
2. Include or attach any additional information you think will help a favorable decision to be made on your adverse determination.

   If you need assistance completing this form, please call the number on the back of the policy holder's ID card.

3. Return completed forms by:
   - Fax: (701) 277-2209
   - Mail: Blue Cross Blue Shield of North Dakota
     PO Box 1570
     Fargo, ND 58107-1570

Provider Instructions

1. Complete Sections A, C, and D of this form
2. Include or attach any additional information you think will help a favorable decision to be made on your adverse determination. Requests submitted without documentation will be denied as an invalid appeal. Please note, the appeal form should not be used to submit a claim correction or as a venue for submitting medical records or EOBs.

   If you need assistance completing this form, please call Provider Services at 1-800-368-2312.

3. Return completed forms by:
   - Fax: (701) 277-2209
   - Mail: Blue Cross Blue Shield of North Dakota
     PO Box 1570
     Fargo, ND 58107-1570

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Appeal Form

Section A: Member Information			
Last Name	First Name		MI
Member ID Number		Date of Birth	
Phone		Claim or Reference Number (if applicable)	
Provider Name		Date of Service	Total Charge Amount

Section B: Authorized Representative Information		
Last Name	First Name	MI
Relationship to Member		
If you are not currently an Authorized Representative, you will need to complete an Authorization to Disclose Health Information (ADHI) form along with this form. Download the ADHI form here		
Phone Number	Address	
City	State	ZIP

Section C: Provider Information			
Last Name	First Name	MI	NPI No.

Check One:

- ☐ Provider on behalf of self
- ☐ Provider on behalf of member

If you are submitting this request on behalf of the member, please complete the Authorization to Release Information (ARI) form along with this form.

Download the ARI form here

Phone Number	Fax Number	Address

City	State	ZIP

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Appeal Form

Section D: Appeal Information

Explain what you are disagreeing with and why you are requesting review of the plan's benefit determination. Include or attach any additional information that would help us make a favorable decision.

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