Vida Appeal Form Instructions

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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Vida Appeal Form

Section A: Member Information

Last Name	First Name	MI
Member ID Number	Date of Birth	
Phone Number	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

Note: 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

Note: 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

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.

Date of Vida Health Exclusion

Reason for Vida Health Exclusion

Are you currently taking Wegovy, Saxenda, or Zepbound? ☐ Yes ☐ No

If yes, what medication are you using and how long have you been using it?

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Section D: Appeal Information (Continued)

What was your baseline weight and BMI before you started using this medication?

What diagnosis or condition are you using or seeking this medication for? (Please submit records that show diagnosis or diagnosed condition)

Are you taking any other medications for weight loss? ☐ Yes ☐ No

If yes, which medications?

What is your most recent BMI? (Please submit records)

Do you have any weight related comorbidities or conditions? (hypertension, diabetes, OSA, CVD, high cholesterol)

Are you of South Asian, Southeast Asian, or East Asian descent? ☐ Yes ☐ No

Note: This information is requested related to comprehensive clinical practice guidelines for medical care of patients with obesity from the American Association of Clinical Endocrinologists and American College of Endocrinology

Please explain your weight loss regimen over the past 6 months (diets, physical activity, behavioral modifications)

Do you plan to continue a weight loss regimen of low-calorie diet, increased physical activity, and behavioral modification over the next 12 months?

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