Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____

BID #: _____ **Claim Number**: _____

Circle one: Covered person Patient Authorized Representative

Contact information of person filing appeal (if different from patient):

Address: _____

Daytime phone: _____ **Email:** _____

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Are you requesting an urgent appeal? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

Please send this form, your denial notice and any supporting documentation to: BlueAdvantage Administrators of Arkansas, Attn: Walmart Appeals, P.O. 1460, Little Rock, AR 72203-1460.

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.