



## Provider Request for Appeal on Behalf of a Medicaid Member

For timely processing of your request, please attach the following information:

1. Copy of the Explanation of Benefits (EOB)/Remittance Advice and/or denial letter
2. Any additional information to support your request (i.e., medical records, etc.)

Mail completed form and any applicable documents to:

Turquoise Care (Medicaid) Appeals Department, P.O. Box 660717, Dallas, TX 75266-0717 Or fax to: 888-240-3004; Attention: Appeals & Grievances.

**Note: Member or patient must sign at the bottom of this form authorizing assignment of representation.**

**Please complete:**

Member/Patient Name: \_\_\_\_\_

BCBSNM Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of the Requestor: \_\_\_\_\_ Date: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Provider(s) Name(s): \_\_\_\_\_

Provider NPI Number(s): \_\_\_\_\_

Provider's reasons for this request (attach additional pages if necessary):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The following documents to support this request are enclosed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I (the patient or parent/guardian) authorize (the requestor): \_\_\_\_\_ to represent me in the appeal process regarding the above services.**

Member/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: If patient is under the age of 18, the signature of the parent/guardian is required.**