BlueCross BlueShield of Illinois

Provider Service Authorization Dispute Resolution Request

This form should be used to dispute a service authorization denial or a reduction, suspension, or termination of a previously authorized service. This form is NOT to be used for claim/billing issues or disputes.

For claim/billing issues or disputes, please use the following link: https://www.bcbsil.com/pdf/network/medicaid_claims_inquiry_dispute_request_form.pdf.

Provider Information

Provider Name: _____

Tax ID Number: _____

National Provider Identifier (NPI) Number: _____

Rendering Provider NPI Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Person for dispute follow up: _____ Phone: _____

Member Information (A separate form must be completed for each member)

Member Name: _____ Date of Birth: _____

Member ID: _____ Authorization Number: _____

Service From/To Date: _____

Reason For Dispute

- ☐ Criteria/Medical Policy utilized
- ☐ Clinical information not available at the time of determination
- ☐ Good cause for failure to obtain authorization
- ☐ Incorrect information provided
- ☐ Member Eligibility Concern
- ☐ Other

To submit by mail: Blue Cross Community Health Plan
Provider Authorization Disputes
PO Box 660906
Dallas, TX 75266

To submit by Fax: 312-653-9443

Providers, please attach additional supporting information for your dispute. The processing time for provider service dispute resolution requests is 30 business days from receipt of the request.