Appeal filing form

Date (mm/dd/yyyy)	**Identification number**	**Subscriber name**
Patient name		**Patient date of birth** (mm/dd/yyyy)
Patient address		**Patient city, state, ZIP**
Daytime phone (including area code)		**Email**
Name of person filing appeal (if other than patient)		**Authorized representative signature** (if other than patient)

Claim information

Date(s) of service	**Claim number(s)**
Provider name (list all that apply)	
Briefly describe the reason for your appeal	**Return mail, fax or email the responses to:** BlueAdvantage Administrators of Arkansas P.O. Box 1460 Little Rock, AR 72203-1460 **Fax:** 501-378-2379 **Email:** TysonServiceTeamBlueAdvClms@arkbluecross.com

Please send your denial notice and any documentation supporting your appeal along with this completed form to the address below. Make sure to keep copies of all documents and correspondence related to your appeal.

Contact Customer Service at **1-800-452-6199** if you have questions or need assistance.