Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____

ID #: _____ **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:

(Signature of person filling appeal)_____

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 documentation supporting your appeal request to:

BlueAdvantage Administrators of Arkansas
Attn: Tyson Appeals
PO Box 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.