

## 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.**