PROVIDER GRIEVANCE FORM

(This is an OPTIONAL form.)

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When a provider disagrees with a payment of a claim, or wishes to grieve a nonpayment issue, the provider may initiate the Provider Grievance Process. For more information, see azblue.com/ProviderDisputes.

Complete form and send with all-inclusive documentation to:

BCBSAZ Appeals and Grievances Department - Mailstop A116
P.O. Box 13466
Phoenix, AZ 85002-3466

Provider Information			
Date (mm/dd/yyyy) / /	Provider Name		
NPI #		Tax ID #	
Mailing Address			
City		State	ZIP Code
Contact Person		Phone #	

Member Information		
Member Name	Member ID #	
Date(s) of Service (mm/dd/yyyy) / /	Claim #	Patient Account #

Reason for Grievance
Please provide a detailed description of the issue and include all-inclusive documentation to support your position (medical records, operative report, etc.)

Please check appropriate box: ☐ Level 1 Grievance *(initial request)* ☐ Level 2 Grievance

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