BlueCross BlueShield of Illinois

INTERNAL – SCAN TO
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Medicare Reconsideration Form

This form is necessary if you would like to submit a request for an adjustment for a claim that was excluded from crossing over to BCBSIL due to the Medicare mass adjustment process, as related to 2010 Medicare Physician Fee Schedule (MPFS) changes and certain provisions of the Affordable Care Act (ACA).

Instructions:

- This form is to be used *only* for Medicare adjustments.
- Submit only one patient per form.
- Complete the entire form, including all required information. (Note: Inquiries received without the member's group and ID number cannot be completed, and may be returned to you to supply this information.)
- **You MUST include a copy of the EOMB from Medicare, and any other necessary documentation.**
- Place your completed form on top of the correspondence you are submitting.
- Mail all required information to:

  Blue Cross and Blue Shield of Illinois
  P.O. Box 805107
  Chicago, IL 60680-4112

- DO NOT attach original claims to this form. If attached, original claims will be returned to you with a letter explaining the correct procedures for submitting claims.

Claim Data *(All fields are required)*	
Group Number: *(From your Provider Claim Summary)*	
Member's ID Number: *(Include three-character alpha prefix)*	
Member's Name: *(Last Name, First Name)*	
Patient's Name: *(Last Name, First Name)*	
Date(s) of Service and Billed Amount:	
DCN – Claim Number Assigned by BCBSIL: *(Do not resubmit the claim unless there are corrections.)*	

Type of Review *(You must include the required documentation)*

☐ Medicare Adjusted EOMB

Additional Details *(Please include, as needed)*

Provider Information *(All fields are required)*					
Provider Name:					
NPI Number:					
Billing Address:					
Email Address:					
Contact Person:		Fax #	( )	Phone #	( )