Value-Based Payment Provider Appeal Form

Note: Please use this form after receiving a response to a THCII reconsideration with which you are still dissatisfied. You must attach this form with any supporting documentation related to your appeal request.

Only one appeal is allowed per episode of care report. We cannot accept requests for *reconsideration* via this form.

Contract ID Number:

Date of Request:

Provider Name: Provider Telephone Number:

Provider Contact Name: Provider Fax Number:

Provider Email:

THCII Tracking Number:

For faster review and processing, please email your appeal form to: THCIIEOCAppeal@bcbst.com

Description of Appeal Request (required):

Notes/Comments: