Horizon BCBSNJ Physician Medical Necessity External Review Request Form

Physician Information

Name: _____
Specialty: _____
NPI Number: _____
Tax ID Number: _____
Billing Address: _____
City: _____
State: _____
Zip **Code**: _____
Contact **Name**: _____
Telephone Number: _____
Fax Number: _____

Subscriber Information

Subscriber Name: _____
Subscriber ID: _____
Group Name: _____
Group Number: _____
Patient Name: _____
Patient ID: _____
Patient Address: _____
City: _____
State: _____
Zip Code: _____

Appeal Information

Claim Number: _____
Date of Service (From): _____
(To): _____
Horizon Service Request# : _____
CPT/HCPCS Codes: _____
Diagnosis Codes: _____
Modifiers: _____
Amount in Dispute: _____
Summary of Appeal: _____
_____
_____
_____
_____
_____

Filing Fee Submitted: ____$50 or ___$25

Mail To:

Crossland Med
Attn: MNRO
PO BOX 487.
Syosset, NY 11791

Crossland will initiate the external review once the external review request form is received and filling fee funds are secure. If an appeal is overturned and in favor of the Physician or Physician Group Crossland will refund the filling fee. Customer Service and Technical Support call 1-800 449-0138.