Blue Cross Blue Shield Blue Care Network of Michigan
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# Provider alert

**Medicare Plus Blue℠ and BCN Advantage℠**

**Categories: Administrative, Authorizations/referrals**

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# How to submit appeals of denied inpatient admissions on behalf of Medicare Advantage members to Grievance and Appeals

As previously communicated, on Dec. 22, 2025, we transitioned the inpatient admission appeal process to our Medicare Plus Blue and BCN Advantage Grievance and Appeals units. As a result of this change, the provider has the right to appeal on behalf of the member for all denied inpatient admissions. This means the provider and the member have the same appeal rights for all adverse decisions.

Note: This change applies only to appeals related to adverse determinations of acute inpatient medical / surgical and behavioral health admissions for Medicare Plus Blue and BCN Advantage members. Blue Cross and BCN commercial members are not included.

## How to submit the appeal

For any denied inpatient authorization issued on or after Dec. 22, submit the appeal to the appropriate Grievance and Appeals unit as outlined below:

| Coverage | How to submit the request |
|---|---|
| Medicare Plus Blue | Mail to:<br>Blue Cross and Blue Shield of Michigan<br>Medicare Advantage<br>Grievances and Appeals Department<br>P.O. Box 2627<br>Detroit, MI 48231-2627<br>Fax: 1-877-348-2251 |
| BCN Advantage | Mail to:<br>BCN Advantage Appeals and Grievance Unit<br>P.O. Box 44200<br>Detroit, MI 48244-0191<br>Fax: 1-866-522-7345 |

## What to submit with the appeal

When submitting an appeal on behalf of a member, you'll get the fastest response by including the following:

- The member's *Integrated Denial Notice (IDN)* letter that was issued with the denial
- Contact information as it appears on the denial letter, including the contact's name, phone number, fax and email

- The member's name, date of birth, contract number (which is the member's identification number from their member ID card) and the date of the service you're appealing (the date of service should not include observation)
- The date the member presented to the hospital
- The date and time the member was admitted to inpatient status, including the documented physician inpatient order
- The reason for the denial, as was referenced in the denial letter
- The physician's and consult's rationale that supports medical necessity for the admission, which is outside of InterQual® criteria
- CPT codes, for a surgical admission
- The physician's discharge summary, if the member has been discharged

If a third-party vendor is submitting the appeal on behalf of the facility, the vendor must include the *Appointment of Representation (AOR)* form with the appeal request. We will accept a standard pre-service reconsideration for service from the member, the member's representative, the member's treating physician acting on behalf of the member, staff of a physician's office acting on the physician's behalf, or any other provider or entity determined to have an appealable interest in the proceeding.

## Timeframe for submitting the appeal

You have the right to request an appeal within 65 calendar days of the date of the denial notice. If you request an appeal after 65 days, you must explain why your appeal is late.

## How to learn more

For more information about submitting appeals of denied inpatient authorization requests, refer to the pertinent provider manual, as follows:

- Medicare Plus Blue: Open the Medicare Plus Blue PPO Provider Manual. Look in the section titled "Appealing Medicare Plus Blue's Decision."
- BCN Advantage: Open the BCN Provider Manual's BCN Advantage chapter. Look in the section titled "BCN Advantage provider appeals."

For more information about this change, see the document titled Transitioning the inpatient admission appeal process to Grievance and Appeals: Frequently asked questions for providers.

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