Capital BlueCross

An Independent Licensee of the Blue Cross and Blue Shield Association

Member Appeal Form

To appeal a claim or denial of service in whole or in part your request must be filed within 180 days of the initial determination. Please attach copies of all documentation you may have in relation to this appeal and include any additional information which may support your appeal. This form and any accompanying documents may be mailed or faxed as follows to:

Member Appeals Department
Capital BlueCross
P.O. Box 779518
Harrisburg, PA 17177-9518
Fax: 717-541-6915

Member Information

Member Name:		Date of Birth:
Address:		
City:	State:	ZIP Code:
Daytime Telephone:	Evening Telephone:	
Identification Number:	Medicare Number:	
Group Name:	Group Number:	

Claim/Service You are Appealing

Hospital:		
City:	State:	ZIP Code:
Doctor:		
City:	State:	ZIP Code:
Other Provider:		
City:	State:	ZIP Code:
Service/Procedure		
Date of Service:	Claim Number:	Authorization Number:

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

Reason for the Appeal

Member Signature:	Date:

If appointing someone to file the appeal on your behalf and to represent you during the course of the appeal, your representative must complete this portion:

Authorization of Designated Appeals Representative

Subscriber:	Today's Date:
Subscriber ID Number:	Group Number:

Section I—Authorization of Designated Appeals Representative

To be completed by the Member:

I authorize _____ to act as my representative in connection with my complaint, grievance, or appeal with Capital BlueCross, or Keystone Health Plan® Central. I authorize this individual to make any request; to present or elicit evidence; to obtain information; and to receive any notice in connection with my complaint, grievance, or appeal. I understand that personal health information related to my claim may be disclosed to my representative in the course of the complaint, grievance, or appeal.

I agree that the representative will act on my behalf regarding my complaint, grievance, or appeal. I understand that:

1. I will not be able to file my own complaint, grievance, or appeal concerning these same services, nor will any other representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative also has the right to rescind this consent at any time.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand this information, and grant my consent for my representative to file a complaint, grievance, and appeal on my behalf.

Member Name:		Date of Birth:
Address:		
City:	State:	ZIP Code:
Daytime Telephone:	Evening Telephone:	
Signature of Member:		Date:

Section 2—Acceptance of Authorization

To be completed by the Representative:

I, _____ hereby accept the above referenced appointment. I am a/an _____ of the Member and will advocate on their behalf in regards to the complaint, grievance, or appeal.

(STATUS OR RELATIONSHIP TO THE PARTY, E.G. RELATIVE, ATTORNEY, FRIEND)

Signature of Representative:		
Name of Representative:		Date:
Address:		
City:	State:	ZIP Code:
Daytime Telephone:	Evening Telephone:	