APPEAL AND GRIEVANCE FORM

Attention: Please place this form before all other documents being submitted

APPEAL OR GRIEVANCE? WHAT IS THE DIFFERENCE?

Request an appeal if you feel we didn't cover or pay enough for a service or drug you received.
Request a grievance if you have a complaint against Blue Cross or your health care provider.

Check One Below

❑ **Member Submitting for Themselves or Others**	❑ **Provider Submitting for Member** Provider appeal must include signed Member Release form to submit for member.

Who is the appeal or grievance for?

Subscriber ID# and health plan name			
First Name	**Last name**	**Preferred Pronouns**	**Date of Birth** ____/_____/______

Who is requesting the appeal?

First Name (If different than above)	**Last name**	**Relationship to member**
Mailing address		
Email Address (optional)		
Phone number	**Day:**	**Evening:**

Appeal or grievance information

What is the appeal or grievance about? **Please describe facts of the appeal/ grievance on Page 2.**	❑ **My claim or authorization was denied.** ❑ **I disagree with what Blue Cross paid.** ❑ **Other** (please specify)

Service category ❑ **Medical** ❑ **Pharmacy** ❑ **Behavioral Health** ❑ **Dental**

Type of service (Example: surgery, lab, office visit, name of medication)

Service date (Put "preservice" if you haven't had the service yet)

Health care provider or facility name

When did you learn of the coverage denial (can be found in the Blue Cross denial letter or claims summary)

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Please describe the facts relating to the appeal or grievance. Including:

- Why you believe we should change our decision.
- Documents that you would like us to consider (letters from providers, medical and lab records, office notes, doctors order)
- Copies of any bills received.

Please include any attempts to resolve the matter before you submitted the request.

Tell us about the issue

Next steps: submit the request.
You can use our appeal form or write your own letter. Return it to us by mail, email or fax.

Mail:	Email:	Fax:
Member Appeal and Grievance Program Blue Cross of Massachusetts One Enterprise Drive Quincy, MA 02171-2126	**grievances@bcbsma.com**	**1-617-246-3616**

What happens next? We will acknowledge the request for appeal or grievance in writing. The acknowledgement will explain the appeal or grievance process and when you may expect our response.

Signature:	Date:

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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