PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Member Appeal Form

To submit an appeal, complete this form and send to the address on page 2.

Section A. – Member information

First name	Last name:	Date of birth: (MM/DD/YY)
		/ /

ID prefix: (see ID card)	ID number: Suffix:	Group/policy number:
	–	

Address:	City/State:	ZIP code:

Phone number:

STOP If you're appealing on the member's behalf, complete section B.
If you're the member, continue to section C.

Section B. – Appealing on a member's behalf

Do you have legal documents to act on the member's behalf?

☐ Yes, I am the legal guardian.

☐ Yes, I have Power of Attorney.

If yes, attach legal documentation and continue to section C.

☐ No, I'm not the legal guardian and I don't have Power of Attorney.

If no, the member listed in section A must complete the following appeal authorization section.

Appeal Authorization:

First name:	Last name:	Phone:

Relationship to member:	Fax:

Address:	City/State:	ZIP code:

Release of Healthcare Information and Records

By signing this form, I understand and agree to the following:

Premera Blue Cross, or any of its affiliates ("the Company"), may disclose my health records to the authorized representative listed on this form.

I understand that the healthcare information may include my benefit, claim, diagnosis, and treatment records including information about the following sensitive healthcare diagnosis and treatment (you may cross off items you prefer not to share).

- Alcohol and/or chemical dependency
- Sexually Transmitted Diseases (including HIV/AIDS)
- Genetic information
- Reproductive health (including abortion)
- Gender-affirming care, gender dysphoria, domestic violence, and behavioral health

You can change your mind and withdraw this release at any time by informing the Company in writing at the address listed on page 2. The Company will make sure the change goes into effect within 5 business days after receiving your withdrawal request and will not be liable for any information released before your change goes into effect. This release is voluntary. We won't condition your health plan enrollment, eligibility for benefits, or claims payment on giving this release. This release lasts 24 months from the signature date or until the appeal process is complete, whichever is earlier.

Member signature: _____ Date: _____

Section C. – Appeal category, provider information

The initial decision was related to: (choose the primary reason)

☐ Pre-service denial (services not provided)	☐ Claim processed at out-of-network benefit level
☐ Experimental/investigational procedure	☐ Benefit limitations
☐ Medical necessity of the service	☐ Cancellation of my policy or eligibility
☐ Other (please specify):	

Please complete the following if related to a medical service:

Provider: (doctor's name, hospital, laboratory)		
Address:	City/State:	ZIP code:
Date of service: MM/DD/YY ☐☐/☐☐/☐☐	Claim #: (Include additional claim numbers in section D.) ☐☐☐☐☐☐☐☐☐☐☐☐☐	Total charge:
Utilization management reference #: (listed in your denial letter) ☐☐☐☐☐☐☐☐☐☐		

Section D. – Appeal details, statement

What would you like us to review? Please provide details and attach supporting documents.	**What action do you want us to take?** If you need more space, you may attach a written statement.

Section E. – Sign and Send

Member signature: X	Date:
Authorized person signature (parent, legal guardian, Power of Attorney) X	Date:
Printed name:	
*Email address:	

Send this completed appeal form and supporting documentation by mail or fax:

Premera Blue Cross
Attn: Member Appeals
PO Box 91102
Seattle, WA 98111-9202
Fax: 425-918-5592

*Get your response by email

☐ By checking this box, you agree to receive your appeal decision and other correspondence related to your appeal via the email address noted in Section E. You can change your mind at any time and/or request a paper copy of any notice by contacting us at the address listed on this form.

PREMERA | BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.