PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
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:

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.

Notice of availability and nondiscrimination **800-508-4722 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

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