BlueCross BlueShield Federal Employee Program®

Member Appeal Form

For requests from Federal Employee Program® **members** for reconsideration of claims for services in **ALASKA** and **WASHINGTON STATE** processed by **Premera Blue Cross**, please complete and send this form by: (1) secure inquiry using your MyBlue account online at FEPBLUE.org; or (2) fax to 1-877-202-3149; or (3) mail to: FEP Appeals, PO Box 91058, Seattle, WA 98111-9158.

Patient Information:	
Subscriber Identification Number (R#):	Patient Name:
Patient Phone Number:	Patient Date of Birth:
Patient Address:	Email Address:
Location of the provider(s) of the services: ☐ **Alaska** ☐ **Washington State** If in another state, please do not use this form. Please refer to your Explanation of Benefits (EOB) or to FEPBlue.org/contact-us to ensure you are submitting your request to the correct company. Do not use this form for Retail Pharmacy program requests.	

Important! Unless your dispute is regarding medical necessity or contract exclusion denial(s), please do not attach medical records.

Disputed Service(s) Information:			
Provider Name(s):	Claim Number(s):	Date(s) of Service:	Total Submitted Charge(s):

Reason for Request and Desired Outcome:

Your Signature and Contact Information:		
Signature:	Date:	Best Phone Number to Reach You:
Printed Name:	Address (if different from patient address):	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other:		

Please type your full name in the signature section if you are completing and submitting this form electronically.
Questions? Please call the customer service number on the back of your member ID card.