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

Provider Appeal Form

Follow the steps below to submit an appeal request to Premera Blue Cross.

A. Provider information:

Who are you appealing for? Please check: ☐ Provider ☐ Member

Provider (e.g.: doctor's name, hospital, laboratory):		
Address:	City/State	ZIP code:
NPI:	Tax ID #:	
Provider contact name:	Phone #:	Fax #:

B. Member information:

First name:	Last name:	Date of birth: MM/DD/YY	
ID prefix:(see ID information)	ID #:	Suffix:	Group/policy #:

STOP If you're appealing on behalf of your patient regarding a pre-service denial or a request to reduce member cost shares, this is known as a member appeal. The member must sign and complete Section C.

C. Member appeal authorization: Who can appeal on your behalf? Check which one applies and sign below.

☐ Provider listed in Section A
☐ Someone else, please provide information below:

First name:	Last name:	Phone:
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: _____

Member printed name: _____

D. What are you appealing?

Type of request (if known):

- ☐ Level I appeal
- ☐ Level II appeal

Please select the one that most applies:

- ☐ Pre-service denial (services not yet provided)
- ☐ Claim/service processed

Please provide information below:

Date of service: MM/DD/YY	Claim number:	Total charge:
Utilization management reference #: (listed on denial letter)		

E. Tell us the why you are appealing:

What would you like us to review again? Write in the space below and be sure to attach supporting documents.	**What action do you want us to take?** Write in the space below. If you need more space, please attach a written statement.

F. Send to the appeals department:

Send completed forms and supporting documents one of two ways:

Fax to:
844-990-0262

Mail to:
Premera Blue Cross
ATTN: Appeals Department
P.O. Box 21702
Eagan, MN 55121

PREMERA | BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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, 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, 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-607-0546 (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 800-607-0546（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-607-0546 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-607-0546 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-607-0546 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-607-0546 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-607-0546 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-607-0546 (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。800-607-0546（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-607-0546 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-607-0546 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-607-0546 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-607-0546 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-607-0546 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-607-0546 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-607-0546 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-607-0546 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-607-0546 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-607-0546 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-607-0546 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-607-0546 (TTY: 711) تماس بگیرید.