

Appeals & Grievances Form



For use by Blue Shield's Medicare Advantage Plan members and Blue Shield's Medicare Prescription Drug Plan members. Request for Appeal and/or Grievance (see reverse for an explanation of a grievance and an appeal)

Member Name:	Member ID#:
Address:	
Phone#:	Authorized Representative:

APPEAL

Denied Service or Claim Number(s) you wish to appeal

Date(s) of Service(s):	Provider Name:
Total Amount in Dispute: \$	Amount paid by Member (if any): \$

Please explain your appeal request in clear, easy to read, detailed form. Please be sure to provide any information you feel may be helpful including copies of any claims/bills, medical records, or denial notices, if available: _____

Standard appeal (redetermination) request must be submitted in writing within 60 days of the date on the notice of denial. Calling Customer Service will initiate a standard appeal, but it cannot be processed without your written request.

GRIEVANCE

Please explain your grievance or issue: _____

A grievance may be filed either orally or in writing within 60 days of the incident. Please note that you may contact our Customer Service Department at the telephone number listed on your Blue Shield member ID card to file a grievance.

Signature: _____ Date: _____
Member (or representative) signature (If representative, please fill out the attached Appointment of Representative (AOR) Form)

Please return this form to the Blue Shield of California
Medicare Appeals & Grievance Department:

Mail Form to: P.O. Box 927 Woodland Hills, CA 91365-9856 or via facsimile at (916) 350-6510	In Person: 6300 Canoga Ave. Woodland Hills, CA 91367
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What is a Grievance?

A type of complaint you make about us or one of our network providers or Pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

What is an Organization Determination?

An Organization Determination is an initial decision by Blue Shield 65 Plus or a person such as your Personal Physician or Physician Group acting on the Plan's behalf, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

What is a Coverage Determination?

A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any; you are required to pay for the service or prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

What is an Appeal?

An appeal is something you do if you disagree with a decision to deny a request for health care services or coverage of prescription drugs, or denial of payment for services or payment for drugs you already received. You may make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan doesn't pay for a drug, item, or service you think you should be able to receive.

If we deny any part of your request for medical care service or payment of a service, you may ask us to reconsider our decision. This is called an "Appeal" or a "request for reconsideration."

Additionally, if we deny any part of your request for Part D prescription drug(s) in our Coverage Determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

Please refer to your *Evidence of Coverage* for a complete description of how to file a grievance and/or appeal.