



MASSACHUSETTS

MEMBER APPEAL & GRIEVANCE FORM

****Attention: place this form before all other documents being submitted****

ARE YOU SUBMITTING an APPEAL or GRIEVANCE?

- Request an Appeal if we didn't cover or pay enough for a service or drug you received
- Request a Grievance if you have a concern with Blue Cross or your health care provider

Check One Below

Member Submitting for Themselves or Others

Form NOT for Provider appeal

Provider Using Member's Appeal

*Form for Member Appeals only & **MUST** include signed Member Release form.*

Who is the appeal or grievance for?

Subscriber ID# and Health Plan name

First Name

Last name

Preferred Pronoun(s)

Date of Birth

____/____/____

Who is requesting the appeal?

First Name (If different than above)

Last name

Relationship to Member

Mailing address

Email Address (optional)

Preferred phone:

Day:

Evening:

Appeal or Grievance Information

What is the appeal or grievance about?
Please describe facts of the appeal/ grievance on Page 2.

- My claim or authorization was denied.
- I disagree with what Blue Cross paid.
- Other (please specify)

Service Category (circle one)

Medical

Pharmacy

Behavioral Health

Dental

Type of Service (Example: surgery, lab, office visit, medication name)

Service date (Put "preservice" if service has not yet happened)

Health care provider or facility name

When did you learn of the coverage denial (can be found in the Blue Cross denial letter or claims summary)

Please describe the facts relating to the appeal or grievance. Including any attempts to resolve the matter beforehand:

- Why you believe we should change our decision.
- Documents that you would like us to consider (letters from providers, medical and lab records, office notes, doctors order)
- Copies of any bills received.

Mail:

Member Appeal and Grievance Program

Blue Cross of Massachusetts
101 Huntington Ave.
Boston, MA 02199

Email:

grievances@bcbsma.com

Fax:

1-617-246-3616

What happens next? We will acknowledge the request for appeal or grievance in writing. The acknowledgement will explain the appeal or grievance process and when you may expect our response.

Signature:

Date:

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).