

## **Member Appeal Form**

PO Box 2100 • Winston Salem, NC 27102-2100

| ☐ Dental Blue ☐ Dental Blue Pr   | referred Denta   | l Blue for Individuals          | Dental Blue Select   |  |
|--|--|---------------------------------|--|--|
| A. Patient/Member Information  |  |                                 |  |  |
| Name   | Phone Numb   |                                 | Birthdate mm dd yyyy                                       |  |
| Street Address   | City   | State                           | Zip Code   |  |
| B. Subscriber/Provider Information   |  |                                 |  |  |
| Primary Subscriber   |  | Subscriber ID Number            |  |  |
| Provider   | der  |                                 | Date of Service  |  |
| Provider Phone Number  | Provider Email Address   |                                 |  |  |
| Reference Number (if available)  | available)   |                                 | Date Form Submitted  |  |
| You have the right to appeal   |  |                                 |  |  |
| In order to start this process, this form must be contification of the date of denial. Please attach cadditional information that may support your apport. This form and information must be submitted to:  Member Rights and Appeals Blue Cross and Blue Shield of North CaPO Box 2100 Winston Salem, NC 27102-2100 Fax: 336-714-0224 In accordance with Blue Cross and Blue Shield of by any Blue Cross NC staff member as is approp | ropies of all documentation of peal.  rolina  f North Carolina policies, all priate. | you may have in relation to thi | is appeal and include any or attached is subject to review |  |
| REASON FOR APPEAL (If additional space is needed, please use the back of this form and/or attach additional sheets as needed)  |  |                                 |  |  |
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| Subscriber Signature   |  | Da                              | te   |  |

| REASON FOR APPEAL (Use this side for additional space and/or attach additional sheets as needed) |   |  |  |  |
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