

Dental Blue
 Dental Blue Preferred
 Dental Blue for Individuals
 Dental Blue Select

A. Patient/Member Information

Name		Phone Number		Birthdate	
				<input type="text"/>	<input type="text"/>
				mm	dd
				yyyy	
Street Address		City		State	Zip Code

B. Subscriber/Provider Information

Primary Subscriber		Subscriber ID Number	
Provider		Date of Service	
Provider Phone Number	Provider Email Address		
Reference Number (if available)		Date Form Submitted	

You have the right to appeal...

In order to start this process, this form must be completed in its entirety, signed and dated, and submitted for review within 180 days of notification of the date of denial. Please attach copies of all documentation you may have in relation to this appeal and include any additional information that may support your appeal.

This form and information must be submitted to:

Member Rights and Appeals
 Blue Cross and Blue Shield of North Carolina
 PO Box 2100
 Winston Salem, NC 27102-2100
 Fax: 336-714-0224

In accordance with Blue Cross and Blue Shield of North Carolina policies, all information contained herein or attached is subject to review by any Blue Cross NC staff member as is appropriate.

REASON FOR APPEAL (If additional space is needed, please use the back of this form and/or attach additional sheets as needed)

Subscriber Signature _____ Date _____

