



PO Box 30055  
Durham, NC 27702-3055

**1**  State Health Plan PPO    Blue Care    Blue Options    Blue Choice  
 Classic Blue    Blue Advantage    Other: \_\_\_\_\_

**2 PATIENT INFORMATION**

NAME \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME TELEPHONE NUMBER \_\_\_\_\_ WORK TELEPHONE NUMBER \_\_\_\_\_

**3 SUBSCRIBER INFORMATION**

SUBSCRIBER	SUBSCRIBER ID NUMBER
PATIENT	DATE OF SERVICE <span style="float: right;">MM/DD/YYYY</span>
PROVIDER	
REFERENCE NUMBER (IF AVAILABLE)	DATE FORM MAILED <span style="float: right;">MM/DD/YYYY</span>

**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 may be submitted to:

Member Rights and Appeals  
Blue Cross and Blue Shield of North Carolina  
PO Box 30055  
Durham, NC 27702-3055  
**Fax:** 919-765-4409  
**Fax (State Health Plan PPO):** 919-765-2322

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

**4 REASON FOR APPEAL**

If additional space is needed, please use the back of this form and/or attach additional sheets as needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5 SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ MM/DD/YYYY