BlueCross BlueShield of North Carolina

Appeal Form

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** MM/DD/YYYY

PROVIDER

REFERENCE NUMBER (IF AVAILABLE) **DATE FORM MAILED** MM/DD/YYYY

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.

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5 **SIGNATURE:** _____ **DATE:** _____ MM/DD/YYYY

6 PRINT