



Member Appeal Request Form

If you got a Notice of Adverse Benefit Determination letter from Healthy Blue and you disagree with our decision, you may fill out this form to ask for an appeal.

Remember, you must ask for an appeal within 60 calendar days from the date on the Notice of Adverse Benefit Determination letter. You may ask for an appeal by filling out this form and sending it to us.

Mail to: Attn: Appeals

Healthy Blue P.O. Box 62429

Virginia Beach, VA 23466-2429 Fax number: 1-866-216-3482

You may also ask for an appeal by sending a letter to the address above or faxing a letter to the fax number above. We'll send you a letter with what we decide within 30 calendar days from the date we get your appeal.

Instructions: Please fill out the form completely and attach any paperwork you want us to review.

SECTION 1: MEMBER INFORMATION

_ Last name	First name	Middle initial		
Date of birth	Phone number	Medicaid ID number		
Email address (optional)	Today's date			
Street address				
- City	State	Zip code		

www.HealthyBlueSC.com

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.

BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

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I am a	asking for an exp	edited (fast) appeal:						
	Yes							
	No							
SECTI	ON 2: APPEAL IN	IFORMATION						
I am filing this appeal because Healthy Blue:								
	Will not pay for a medical service I received.Will not say it is OK for me to get a medical service.							
□ Stopped paying for a medical service I was receiving.								
□ Took too long to decide if it would pay for a medical service.								
Signature Date								
SECTI	ON 3: REPRESEN	ITATIVE INFORMATION						
I have	a representativ	e who is helping me file this appeal	l.					
Note:	A representative	e is not required.						
Last n	ame	First name	Middle initial					
		Charles III.						
Pnone	number	Street address						
 City		State	Zip code					

You may choose anyone you wish to help you file an appeal, including an attorney or a doctor. If you choose to have someone help you file the appeal, you need to fill out an Appeal Representative Form. You can get the form at www.HealthyBlueSC.com and include it with your appeal request. Or we'll send you a form if you checked the box above. You must sign the Appeal Representative Form and return it to us before we can act on your appeal.

SECTION 4: ADDITIONAL INFORMATION

Please write any additional information you feel may be helpful with your appeal request. Tell us why you are appealing and why you disagree with our decision. Please provide us with the names of any providers who may have records about the service in question.

This information becomes part of the permanent record. Please write clearly. Use extra paper if needed.

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If you need help with this form, call the phone number on your Healthy Blue ID card.

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Notice of Non-Discrimination

BlueChoice HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueChoice HealthPlan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Language Services

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-866-781-5094 (TTY 1-866-773-9634).

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-866-781-5094 (TTY 1-866-773-9634).

هل تحتاج إلى مساعدة في رعايتك الصحية أو في التحدث معنا أو قراءة ما نقوم بإرساله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى بدون تكلفة عليك. اتصل بنا على الرقم المجاني 5094-781-866-1 (773-864-773-861).

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