Member Appeal Request Form

If you got a Notice of Adverse Benefit Determination or denial from Healthy Blue and you disagree with our decision, you may ask for an appeal either orally or in writing. You must ask for an appeal within 60 calendar days from the date on the Notice of Adverse Benefit Determination or denial. If asking for an appeal in writing, you may send it to us by filling out this form, mailing a letter to the address below, or faxing a letter to the fax number below. We'll send you a letter with our decision within 30 calendar days from the date we get your appeal.

Mail to:

Pharmacy - CarelonRx Appeal Department
P.O. Box 775370
St. Louis, MO 63177
Fax number: 844-430-6802

CVS Caremark Specialty Drug Appeals Department
800 Biermann Court
Mount Prospect, IL 60056
Phone Number: 844-345-2803 (TTY 711)
Fax number: 888-648-9622

CarelonRx is an independent company that administers pharmacy benefits for Healthy Blue members on behalf of BlueChoice HealthPlan.
CVS Caremark®, is a separate company providing utilization review services on behalf of BlueChoice HealthPlan.

BC-11032023-M-8.1.WM-R

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

I am asking for an expedited (fast) appeal:

- ☐ Yes
- ☐ No

SECTION 2: APPEAL INFORMATION

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

SECTION 3: REPRESENTATIVE INFORMATION

I have a representative who is helping me file this appeal.

Note: A representative is **not** required.

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Last name | First name | Middle initial

Phone 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.

If you need help with this form, call Pharmacy Customer Service at **866-781-5094 (TTY 866-773-9634)**, 24 hours a day, seven days a week.

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

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