



MEMBER APPEAL REPRESENTATIVE FORM

Member Name: _____

Member Address: _____

City, State, ZIP: _____

I choose the following person to act on my behalf and represent me in my appeal process with Healthy Blue: _____

(Name of Representative)

Member Signature: _____

Date: _____

Please mail or fax to:

Pharmacy - CarelonRx Appeals 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

www.HealthyBlueSC.com

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[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.]