

MEDICARE ADVANTAGE Appeal & Grievance Form



An Independent Licensee of the Blue Cross Blue Shield Association

You can use this form to file an appeal or grievance. Definitions and helpful information are at the end of this form. Please type or print in dark ink.

What is your request or concern about? Prescription drug Medical care
Did you already receive the prescription drugs or medical care? Yes No

Please tell us what you want to do:

- File a standard appeal:** ask us to reconsider how we cover or pay for your care or prescription drugs. You must file within 65 calendar days from the date we denied the service or drug.
- File an expedited (fast) appeal:** an appeal you make when your doctor believes your health depends on a faster answer. You'll need to make this appeal before you get the service or drug. We'll give you an answer no later than 72 hours. You must file within 65 calendar days from the date we denied the service or drug.
- File a grievance:** a complaint about quality of care you received, waiting times, customer service, or something similar from our plan or our providers. You must file within 65 calendar days from the date the event happened.
- File an expedited (fast) grievance:** This is a complaint you can file **only** after we've determined your appeal doesn't qualify as an expedited appeal. Or, when we've told you we will take an extra 14 calendar days, and you disagree with this action. You must file within 65 calendar days from the date we tell you how much time we'll take.

What you can do if your 65-calendar-day deadline has passed.

You may need to show you have a good reason for filing it late. (Examples: you were too sick, or you just received your bill.) More about deadlines and filing is at the end of this form. Please give your reason below:

Member Information

Member ID _____ \ \ _____
Date of Birth

First Name _____ Last Name _____

Address _____

City _____ State _____ ZIP Code _____

Home Phone Number _____ Cell Phone Number _____

Email Address _____

Are you completing this form for the member? If yes, give your name, address, and phone number:

First Name

Last Name

Phone Number

Address

City

State

ZIP Code

What is your relationship to the member?

Spouse or partner Relative Attorney Estate representative Other _____

Please include a copy of the paperwork showing you have the legal right to act for the member. Examples: Durable Power of Attorney or Appointment of Representative (AOR) form. You can find the AOR form [here](#).

Information about your plan

Plan Name

Member ID Number

Information about your request

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Date of Service

Claim Number or Prior Authorization Number

Provider

Location

Description of medical care or prescription drug name

Please tell us what happened. (Examples: you asked the plan to pay for medical care or a prescription drug and we denied it.) You may attach extra pages if you need more space. Be sure to include them when you send this form.

What results do you want? (Example: have the plan pay for medical care or a drug.) Please tell us below.

Sign Here

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Date

When I sign above, I am stating the information on this form is correct, to the best of my knowledge. I understand if I put information on this form I know isn't true, I could face fines and prison under Federal law. If I sign as an authorized representative, it means I have the legal right under State law to sign. I can show written proof of this right if the Blue Cross® Blue Shield® of Arizona (AZ Blue) Medicare Advantage plan asks for it.

Checklist

Please make sure you:

- Sign above.
- Keep copies of everything you send us.
- If you are completing this for a member, please include a copy of the paperwork showing you have the legal right to do so. Examples: Durable Power of Attorney or Appointment of Representative (AOR) form. You can find the AOR form [here](#).

Where to send this form

Mail: Blue Cross Blue Shield of Arizona
Appeals and Grievances Department
PO Box 29234
Phoenix, AZ 85038

Fax: Standard 602-544-5656
Expedited 602-544-5655

Email: grievanceappeals@azblue.com

Definitions and helpful information

Standard Appeal

- Request for Service: For services you haven't received yet, we'll give you a written decision within 7 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed.
- Request for Payment: For appeals related to payment of a medical service/item or Medicare Part B drug you already received, we'll give you a written decision within 60 days. You can't ask for a fast appeal if you're using us to pay you back for a medical service/item or Medicare Part B drug you already received.

Fast Appeal (only available for service requests)

- We'll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a standard appeal.
- We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. For a fast appeal without support from a doctor, we'll decide whether your request requires a fast appeal. If we don't give you a fast appeal, we'll process a standard appeal.

Standard Grievance

- A complaint when you are dissatisfied with the quality of service or care that the plan or a provider gave you. (Examples: rude customer service, a problem with a network facility or provider, confusing member materials.) We'll respond to your grievance within 30 calendar days.

Expedited Grievance

- This is a complaint you can file only after we've determined your appeal doesn't qualify as an expedited appeal. Or, when we've told you we will take an extra 14 calendar days, you can disagree with this action. Be sure to file no later than 65 calendar days from the date we tell you how much time we'll take. If we determine your expedited appeal qualifies, we'll respond to your expedited grievance within 24 hours.

Please include any other information with this form that you would like to provide to help us research your appeal or grievance. If you use extra pages, be sure to mail or fax them to us with this form.

Questions?

Please contact Member Services at **480-937-0409** (in Arizona) or toll-free at **1-800-446-8331**, **TTY: 711**. Hours are 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30; and 7 days a week from October 1 to March 31.