BlueCross BlueShield Minnesota

Request for Appeal (Member Form)

Thank you for choosing Blue Plus as your health plan. Your health is very important to us. To ask for an appeal, please fill out and mail us this form. It will help us look at your request. We will send you a letter within 10 business days to let you know we got the form. We will send you a letter within 30 calendar days after we get the form or your verbal appeal to let you know what we decide.

Member Name:_____

Parent or Guardian Name (if service is for a child):_____

Blue Plus ID #:_____

Reference Number:_____

Name of doctor who wants to give or who gave you the service:_____

Doctor office address:_____

_____

Doctor office phone number(s):_____ / _____

Type of service you want or got:_____

Why you want or got the service:_____

Date you want to have or had the service:_____

Why you are asking for an appeal:_____

_____

_____

_____

_____

Sign and send this form to:

Central Appeals Processing
Blue Plus
P.O. Box 64033
St. Paul, MN 55164-4033
Fax: 1-833-224-6929

Signature:_____ **Date**:_____

Member, Parent, Legal Guardian or Approved Rep*

*An approved rep must be named by the member, parent or legal guardian. The provider may act on behalf of the member with the member's/responsible party's written consent. An approved rep cannot make health care decisions that involve the financial duty of the member, parent or legal guardian unless it is put in writing.

bluecrossmn.com/publicprograms

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If you need help with your request for an appeal, please call Member Services toll free at **1-800-711-9862 (TTY 711)**. You can call during our normal business hours from 8 a.m. to 5 p.m. Central time, Monday through Friday, except holidays.