Blue Cross and Blue Shield of Minnesota Self-Insured

COMPLAINT FORM

| Inquirer Name: | | | Daytime Phone #: |
|---|---|---|---|
| Address: | | | |
| City: | St: | Zip: | Patient Name: |
| Identification Number: | | | Group Number: |
| Claim Number(s) in question: | | | Date of Service: |
| | | | |
| | | | |
| | | | |

| Is this your first written request of this issue? | ☐ | Yes | ☐ | No |
|---|---|---|---|---|
| What is your complaint / concern regarding (choose or describe): | | | | |
| ☐ | Denial of your application for coverage | | | |
| ☐ | Effective/Termination date | | | |
| ☐ | Quality of Care / Quality of Service Complaint | | | |
| ☐ | Other – Please specify below | | | |
| Please provide a narrative description of the complaint or problem and your ideal resolution in the space provided or attach a separate sheet (include names and dates whenever possible): | | | | |
| | | | | |
| I hereby authorize Blue Cross to forward a copy of this information to the provider if necessary to conduct our internal review of the situation. | | | | |
| Signature | | | Date | |
| For specific details on the complaint process, please refer to your Summary Plan Description. | | | | |



Blue Cross® and Blue Shield® of Minnesota is a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Minnesota Self-Insured
COMPLAINT FORM

You may appeal a denial or partial denial of your claim by following our complaint procedures. You have the right to have someone assist you or act on your behalf. If you wish to designate someone to act on your behalf please contact customer service to obtain an Authorization for Release of Information. If you need help completing this complaint form, please contact customer service. Your customer service telephone number is located on the back of your identification card.

1. You may submit this form and any documents, records, or other information that relates to your complaint. A full and fair review of your complaint will be provided. Notice of the resolution will be provided in writing and mailed to you. If your complaint is related to a pre-service denial, notice will be sent within 30 days of the date we receive your complaint. For all other complaints, including complaints related to a post-service denial, notice will be sent within 60 days of the date your complaint is received.

2. If you are not satisfied with the outcome we have offered, you may have additional appeal rights either through Blue Cross Blue Shield of Minnesota or your employer. These options may include a hearing and/or a written reconsideration process. We will notify you of your further appeal rights, as described in your Summary Plan Description, in our written response to your complaint.

3. If your group health plan is subject to ERISA**,** once you have completed the formal complaint process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.

Please send this completed form to:

Blue Cross and Blue Shield of Minnesota
Attention: Consumer Service Center
PO Box 64560
St. Paul, MN 55164
Fax (651) 662-2745

Customer Service
1-800-382-2000

*Or contact the customer service number on the back of your identification card.*

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-8000** (voice), or **1-800-382-2000** (toll free).

**For TTY:**
Call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Hours: 7 a.m. to 8 p.m. Central Time, Monday through Friday

Attention: If you want free help translating this information, call the above number.
Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.