

MEMBER APPEAL FORM

We are extremely interested in addressing your appeal. This form is used to gather important information necessary to research this appeal. Please provide as much information as possible below.

Member Name: \_\_\_\_\_ ID No: \_\_\_\_\_

Please give the date(s) of service involved: \_\_\_\_\_

If the appeal involves more than one physician or provider, please list the name(s) of those involved:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe the reason for your appeal:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mail To: BCBSRI/BlueCHiP  
Attn: Grievance and Appeals Unit  
500 Exchange Street  
Providence, RI 02903

Disclosure Statement:

By signing this form you are allowing us to use your name if we need to contact individuals for information. If you do not sign this form, our ability to fully review your complaint may be affected.

Disclosure Accepted  Disclosure Denied   
*Please check one of the boxes above.*

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date