Community Health Plan
Maryland

Appeals and Grievance Form

Use this form if you want to tell us you have a complaint or when you don't agree with a decision we made about your health care (an appeal). For help with this form, please call us at 1-410-779-9369 or 1-800-730-8530. TTY users should call 711. Our Member Services staff can talk to you Monday to Friday from 8 am to 5 pm.

Member Name: __________________________ Member ID: ____________Today's Date___________

Member ID Number: ______________________

Phone Number: Home: ___________________ Cell: __________________Other:_________________

Please tell us why you are filing this complaint:

□ You don't agree with an decision we made not to cover a service your doctor asked for (appeal)
□ You have a complaint (grievance)
Tell us more (you can attach a separate piece of paper if you need more room)

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Name of Member's Primary Care Provider Name (if applicable):_______________________________

Date(s) of Service (if needed) ____

It may take us up to 30 days to get back to you.
Do you or your doctor think that waiting 30 days could be bad for your health?
□ Yes □ No
If yes, please tell us why (you can attach a separate piece of paper if you need more room)

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Signature of CareFirst BlueCross BlueShield Community Health Plan Maryland:

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Please fax the form to 410-779-9367 or mail it to:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attention: Appeals & Grievances Department
1966 Greenspring Drive, Suite 100
Lutherville-Timonium, MD 21093

If you are NOT the CareFirst BlueCross BlueShield Community Health Plan Maryland member, but are filing this on behalf of the CareFirst BlueCross BlueShield Community Health Plan Maryland member, complete this section. Unless you are the parent of the member, federal and state laws require us to get official authorization for you to represent our member. If the CareFirst BlueCross BlueShield Community Health Plan Maryland member has not signed this document, you need to attach a completed Appointment of Representative Form; a letter from our member letting us know that you can represent them; proof of guardianship; or Durable Power of Attorney for Health Care.

Signature of Representative: _____________________Your Name: ____

Relationship to Member:

____

Phone Number: Home: ___________________ Cell: __________________Other:____________________________

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