Capital BLUE

Member Appeal Form

To appeal a claim or denial of service in whole or in part your request must be filed within 180 days of the initial determination. Please attach copies of all documentation you may have in relation to this appeal and include any additional information which may support your appeal. This form and any accompanying documents may be mailed or faxed as follows to:

Member Appeals Department
Capital BlueCross
P.O. Box 779518
Harrisburg, PA 17177-9518
Fax: 717.541.6915

Member Information

Member Name (individual the appeal is about):		Date of Birth:
Mailing Address:		
City:	State:	ZIP Code:
Daytime Telephone:	Evening Telephone:	
Identification Number:	Medicare Number:	
Group Name:	Group Number:	

Claim/Service You are Appealing

Hospital:		
City:	State:	ZIP Code:
Doctor:		
City:	State:	ZIP Code:
Other Provider:		
City:	State:	ZIP Code:
Service/Procedure		
Date of Service:	Claim Number:	Authorization Number:

Reason for the Appeal

Member Signature:	Date:

If appointing someone to file the appeal on your behalf and to represent you during the course of the appeal, you and your representative must complete this portion:

Authorization of Designated Appeals Representative (ADAR)

Subscriber:	Today's Date:
Subscriber ID Number:	Group Number:

Section I—Authorization of Designated Appeals Representative

To be completed by the member:

I authorize _____ to act as my representative in
(NAME OF THE INDIVIDUAL APPOINTED AS REPRESENTATIVE)
connection with my complaint, grievance, or appeal with Capital BlueCross, or Keystone Health Plan® Central, Inc. I authorize this individual to make any request; to present or elicit evidence; to obtain information; and to receive any notice in connection with my complaint, grievance, or appeal. I understand that personal health information related to my claim may be disclosed to my representative in the course of the complaint, grievance, or appeal.
I agree that the representative will act on my behalf regarding my complaint, grievance, or appeal. I understand that:

1. I will not be able to file my own complaint, grievance, or appeal concerning these same services, nor will any other representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative also has the right to rescind this consent at any time.
3. When the plan takes action or issues correspondence, it shall send notice to only the authorized representative. Notice shall not be sent to the party if there is an authorized representative.
4. The plan shall send any requests for information or evidence regarding an appeal only to the authorized representative.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand this information, and grant my consent for my representative to file a complaint, grievance, and appeal on my behalf.

Member Name (individual the appeal is about):		Date of Birth:
Mailing Address:		
City:	State:	ZIP Code:
Daytime Telephone:	Evening Telephone:	
Signature of Member:		Date:

Section 2—Acceptance of Authorization

To be completed by the representative:

I, _____ hereby accept the above referenced
(NAME OF THE INDIVIDUAL APPOINTED AS REPRESENTATIVE)

appointment. I am a/an _____ of the member and will
(STATUS OR RELATIONSHIP TO THE PARTY, E.G. RELATIVE, ATTORNEY, FRIEND)
advocate on their behalf in regards to the complaint, grievance, or appeal.

I understand that as the Authorized Representative I am accountable to:

1. Inform the party of the scope and responsibilities of the representation;
2. Inform the party of the status of the complaint, grievance, or appeal and the results of actions taken on behalf of the party such as notification of complaint, grievance, or appeal determinations, decisions, and further appeal rights; and
3. Disclose to a member any financial risk and liability that the member may have.

Name of Representative:		
Mailing Address:		
City:	State:	ZIP Code:
Daytime Telephone:	Evening Telephone:	
Signature of Representative:	Date:	

Completing a Valid ADAR Form:

A. Section I–Authorization of Designated Appeals Representative (ADAR)–The name of the party making the appointment must be clearly legible. The party making the appointment includes their handwritten ink signature, address, and phone number. If the party that wishes to appoint a representative is a member, then only the member or the member's legal guardian may sign. The date the party signs the form must be included.

B. Section II–Acceptance of Authorization–An organization or entity may not be named as a representative, but rather a specific member of that organization or entity must be named. This ensures that confidential member information is released only to the individual so named. The name of the individual appointed as representative must always be completed, and his/her relationship to the party entered. The individual being appointed signs the form with a handwritten ink signature, dates, and completes the rest of this section. A representative must sign the authorization within 30 calendar days of the party's signature.

C. If any of the required elements listed above are missing from the ADAR, or are determined to be invalid, the authorization is considered defective.