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:

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Authorization of Designated Appeals Representative

Section I—Authorization of Designated Appeals Representative (ADAR)

To be completed by the member:

I authorize _____ to act as my representative in connection
(NAME OF THE INDIVIDUAL APPOINTED AS REPRESENTATIVE)

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 medical information related to my appeal may be disclosed to my Designated Appeals Representative indicated below.

I agree that the Designated Appeals 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grievance, or appeal concerning these same services, nor will my legal representative, unless this consent is rescinded in writing.
2. I have the 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 only to my Designated Appeals Representative. Notice shall not be sent to me or my legal representative if there is a Designated Appeals Representative.
4. The plan shall send any requests for information or evidence regarding an appeal only to the Designated Appeals Representative.

I have read this consent, including the instructions on the back of this form, 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 Designated Appeals Representative to file a complaint, grievance, or appeal on my behalf.

Member Name (individual the appeal is about):	Date of Birth:	
Number on ID Card:	Telephone Number:	
Mailing Address:		
City:	State:	ZIP Code:
Services being Appealed:		
Signature of Member (or legal representative):	Date:	

Section II—Acceptance of Authorization

To be completed by the Representative:

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

I am a/an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

of the member and will advocate on their behalf in regards to the complaint, grievance, or appeal. I understand that as the Designated Appeals 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 the member any financial risk and liability that the member may have.

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

This form and any accompanying documents may be mailed or faxed as follows to:
Member Appeals Department, Capital BlueCross, PO Box 779518, Harrisburg, PA 17177-9518, Fax: 717.541.6915

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. If the party making the appointment is the provider or supplier, the provider or supplier (or person authorized to act on behalf of the provider or supplier) must sign the form and complete this section. 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.

Authority of an Authorized Designated Appeals Representative:

A. A representative may represent a party in a complaint, grievance, or appeal. An authorized representative may, on behalf of the party, obtain complaint, grievance, or appeal information to the same extent as the party; submit evidence; make statements about facts and law; and make any request; or give or receive any notice about the complaint, grievance, or appeal records.

Duration of Authorization:

A. An authorization is considered valid for one (1) year from the date that both parties signed the form. Requiring that a new authorization be executed on a yearly basis will help ensure that there is an ongoing relationship between the party and his/her representative.

B. Appeals for other claims may be initiated utilizing an existing authorization instrument within one year of the effective date of the authorization (i.e., the date a completed authorization instrument is signed by the party and the appointed representative). When initiating a new appeal within the one year time frame, the representative must file a copy of the completed ADAR Form with the complaint, grievance, or appeal request. Allowing the representative to use the same authorization for up to one year will help reduce the paperwork involved in representing parties.

C. The authorization remains valid throughout any and all subsequent levels of complaint, grievance, or appeal on the item(s), claim(s) or service(s) at issue. Therefore, the representative need not secure a new authorization when proceeding to the next level of complaint, grievance, or appeal on the same items, services or claim(s). This holds true regardless of the length of time it may take to resolve the complaint, grievance, or appeal.