Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Capital

CONSENT FOR PROVIDER TO FILE A GRIEVANCE FOR ENROLLEE

Name of enrollee:	**Enrollee's date of birth:**
Enrollee Unique Client Identifier (UCI) number:	**Member ID number:**
Enrollee mailing address:	
Enrollee daytime telephone number:	**Enrollee evening telephone number:**

Provider name:	**Provider plan ID number:**
Provider address:	
Description of specific service or item for which I agree the provider can file a grievance:	**Name and address of MCO where grievance will be filed:** **Capital Blue Cross** **PO Box 779518** **Harrisburg, PA 17177-9518**

I,_____, agree that _____ can file a grievance for me with Capital Blue Cross about the service or item described above.

By signing this consent form, I understand the following:

1. I or my representative may not file a grievance about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the grievance process by telling Capital Blue Cross and _____ in writing that I do not want _____ to continue the grievance process for me.
2. My consent to have the provider file the grievance for me will automatically no longer be in effect if the provider does not file a grievance or does not continue with the grievance through the end of the grievance review process.
3. I or my representative have read or have been read this provider consent form and have had it explained to me until I understand it. I or my representative understands the information in this consent form.

Signature of enrollee or representative _____ Date _____

Witness signature _____ Date _____

Print witness name _____

If the enrollee is unable to sign this consent form because the enrollee is legally incompetent:

Name of person signing on behalf of enrollee _____

Address of person signing on behalf of enrollee _____

Relationship of person signing on behalf of enrollee _____

This form can be faxed or mailed to:

Mailing address:
Member Appeals
Capital Blue Cross
PO Box 779518
Harrisburg, PA 17177-9518

Fax number: 717.541.6915