Blue Cross Blue Shield of Minnesota Blue Plus
COMPLAINT FORM

Inquirer Name:_____

Daytime Phone Number: _____

Address:
_____

_____

Patient Name: _____

Identification Number: _____

Group Number: _____

Claim Number(s) in question:

_____

_____

Date of Service:

_____

_____

Is this your first written request of this issue? ☐ Yes ☐ No

What is your complaint / concern regarding (choose or describe):

- ☐ Denial of your application for coverage
- ☐ Effective / Termination date
- ☐ Quality of Care / Quality of Service Complaint
- ☐ Other - Please specify below

Please provide a narrative description of the complaint or problem and your ideal resolution in the space provided or attach a separate sheet (include names and dates whenever possible):

_____

_____

_____

_____

_____

_____

_____

_____

I hereby authorize you to forward a copy of this information to the provider, if necessary to conduct our internal review of the situation.

Signature_____ Date _____

For specific details on the complaint process, please refer to your Benefit Booklet.

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You may appeal a denial or partial denial of your claim by following our complaint procedures. You have the right to have someone assist you or act on your behalf. If you wish to designate someone to act on your behalf please contact customer service to obtain an Authorization for Release of Information. If you need help completing this complaint form, please contact customer service. Your customer service telephone number is located on the back of your identification card.

1. You may submit any documents, records, or other information that relates to your claim for benefits. You may file a formal written complaint or contact us by telephone to file a formal complaint. A full and fair review of your complaint will be provided. Notice of the resolution will be provided in writing and mailed to you within 30 days after the formal complaint is received. If a decision cannot be made within 30 days due to circumstances outside of our control, we may take an additional 14 days to notify you provided we notify you in advance of the extension and the reason(s) for the delay.
2. If you are not satisfied with our decision, you may elect to further appeal to Blue Cross Blue Shield of Minnesota by sending a letter requesting that our Corporate Appeals Committee review a reconsideration or requesting the Committee to hear your concerns, either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received. If you request to present your concerns before the Committee, a meeting will take place within 40 days of our receipt of your request and a decision will be made within 5 days following the meeting.
3. If you are still not satisfied with the outcome we have offered and you have completed our internal review process, including Corporate Appeal (item 2), you may be eligible to submit your complaint for external review by a third party. The review is completed by an independent review organization, MAXIMUS Center for Health Dispute Resolution. The written request for review must be submitted to the Minnesota Department of Health along with a $25 filing fee. The Minnesota Department of Health may waive this fee in cases of financial hardship. Additional information regarding this process will be provided in our notification to you.
4. If your group health plan is subject, you may contact the Minnesota Department of Health at any time: (651) 282-5600 or toll-free at 1-800-657-3916.
5. If your group health plan is subject to ERISA**,** once you have completed the formal complaint process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.

Please send this completed form to:

Blue Cross Blue Shield of Minnesota and Blue Plus
Attention: Consumer Service Center
PO Box 64560
St. Paul, MN 55164
Fax (651) 662-2745

Customer Service
1-800-382-2000

Or contact the customer service number on the back of your identification card.