

Fully Insured Complaint Form



Insured Information

Inquirer Name:			Daytime Phone #:		
Address:					
City:		St:	Zip:	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):

- Enrollment/Membership Issue
- Pre-Service Issue (Prior Authorization Denial)
- Post-Service Issue (i.e. claim, benefit)
- 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 Blue Cross to forward a copy of this information to the provider if necessary to conduct our internal review of the situation.

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

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Minnesota Fully-Insured
COMPLAINT FORM

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 Disclosure of Health 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.
 - **Pre-Service and Post-Service Medical Determinations:** Notice of the resolution will be provided in writing and mailed to you within 15 days after the formal complaint is received. If a decision cannot be made within 15 days due to circumstances outside of our control, we may take an additional 4 days to make a decision, provided we notify you in advance of the extension and the reason(s) for the delay.
 - **Post-Service Non-Medical Determinations:** 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 make a decision, 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 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 third party. The review is completed by an independent review organization. The written request for review must be submitted to the Minnesota Department of Commerce along with a \$25 filing fee. The Minnesota Department of Commerce may waive this fee in cases of financial hardship. Additional information regarding this process will be provided in our notification to you.
4. You may contact the Minnesota Department of Commerce at any time: 651-539-1600 or 1-800-657-3602
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 the address below or fax the form to (651) 662-2745

Blue Cross and Blue Shield of Minnesota
PO Box 982800
Attention: Appeals and Grievances
El Paso, TX 79998

This information is also available in other ways to people with disabilities by calling customer service at **(651) 539-1600, 1-800-382-2000** (toll free), or call the customer service number on the back of your identification card

For TTY:

Call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Attention: If you want free help translating this information, call the above number.

Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.