BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Medicare Advantage / Prescription Drug Appeal & Grievance Form

You can use this form to file an appeal or grievance. Definitions and helpful information are at the end of this form. Please type or print in dark ink.

What is your issue or concern about? ☐ Prescription drug ☐ Medical care

Did you already receive the prescription drugs or medical care? ☐ Yes ☐ No

Please tell us what you want to do:

☐ **File a standard appeal:** ask us to reconsider how we cover or pay for your care or prescription drugs. You must file within 60 calendar days from the date we denied the service or drug.

☐ **File an expedited (fast) appeal:** an appeal you make when your doctor believes your health depends on a faster answer. You'll need to make this appeal before you get the service or drug. We'll give you an answer no later than 72 hours. You must file within 60 calendar days from the date we denied the service or drug.

☐ **File a grievance:** a complaint about quality of care you received, waiting times, customer service or something similar from our plan or our providers. You must file within 60 calendar days from the date the event happened.

☐ **File an expedited (fast) grievance:** This is a complaint you can file **only** after we've determined your appeal doesn't qualify as an expedited appeal. Or, when we've told you we will take an extra 14 calendar days, and you disagree with this action. You must file within 60 calendar days from the date we tell you how much time we'll take.

What you can do if your 60-calendar-day deadline has passed.
You may need to show you have a good reason for filing it late. (Examples: you were too sick, or we gave you the wrong deadline.) More about deadlines and filing is at the end of this form. Please give your reason below:

Information about you

First Name	Last Name	
Address		
City	State	ZIP code
Home phone number ___ – ___ – ____	Cell phone number ___ – ___ – ____	
Email address		

Are you completing this form for the member? If yes, give your name, address and phone number:

First Name	Last Name	Phone number
		– –

Address

City	State	ZIP code

What is your relationship to the member?

☐ Spouse or partner ☐ Relative ☐ Attorney ☐ Estate representative ☐ Other_____

Please include a copy of the paperwork showing you have the legal right to act for the member. Examples: Durable Power of Attorney or Appointment of Representative (AOR) form. You can find the AOR form here: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html

Information about your plan

Plan name

Member ID number

Information about your issue

Date of service	Claim number or Prior Authorization number

Provider	Location

Description of medical care or prescription drug name

Please tell us what happened. (Examples: you asked the plan to pay for medical care or a prescription drug and we denied it.) You may attach extra pages if you need more space. Be sure to include them when you send this form.

What results do you want? (Example: have the plan pay for medical care or a drug.) Please tell us below.

Sign here	**Date**

When I sign above, I am stating the information on this form is correct, to the best of my knowledge. I understand if I put information on this form I know isn't true, I could face fines and prison under Federal law. If I sign as an authorized representative, it means I have the legal right under State law to sign. I can show written proof of this right if the MA/PD plan asks for it.

Checklist

Please make sure you:

- ☐ Sign above.
- ☐ Keep copies of everything you send us.
- ☐ If you are completing this for a member, please include a copy of the paperwork showing you have the legal right to do so. Examples: Durable Power of Attorney or Appointment of Representative (AOR) form. You can find the AOR form here: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html

Where to send this form

Medical Services Appeals and Grievances

Mail: Blue Cross Blue Shield of Arizona
Appeals and Grievances
Department
PO Box 29234
Phoenix AZ 85038

Fax: Standard (602) 544-5656
Expedited (602) 544-5655

Prescription Drug Appeals and Grievances

Mail: Blue Cross Blue Shield of Arizona
Appeals and Grievances
Department
PO Box 29234
Phoenix AZ 85038

Fax: Standard (602) 544-5657
Expedited (602) 544-5655

Definitions and helpful information

Appeal

An action you can take if you disagree with a coverage or payment decision the plan made. For example, you can appeal if Medicare or your plan denies your request for:

- A health care service, supply, item, or prescription drug you think you should be able to get.
- Payment of a health care service, supply, item, or prescription drug you've already received.
- A change to the amount you must pay for a health care service, supply, item, or prescription drug.

Our deadline for a prescription drug appeal

- For a prescription drug you think you should be able to get: 7 calendar days.
- For a prescription drug you've already received and paid for out-of-pocket: 14 calendar days. (If we agree with you, we will issue payment within 30 calendar days from the date we received your appeal.)

Our deadlines for a medical-related appeal

The standard timeframes are:

- For a health care service, supply or item you think you should be able to get: 30 calendar days.
- For a health care service, supply or item you've already received: 60 calendar days.
- To change the amount you must pay for a health care service, supply or item: 30 calendar days.

Expedited appeal

An action you can take if you and/or your doctor believe that waiting for a decision under the standard time frame will place your life, health, or ability to regain function in serious jeopardy.

Our deadline for an expedited appeal

For prescription drug and medical issues: 72 hours. Your appeal won't be expedited if you've already received the drug or service you are appealing.

Expedited grievance
This is a complaint you can file only after we've determined your appeal doesn't qualify as an expedited appeal. Or, when we've told you we will take an extra 14 calendar days, and you disagree with this action. Be sure to file no later than 60 calendar days from the date we tell you how much time we'll take.

Our deadline for an expedited grievance
The standard timeframe is 24 hours.

Grievance
A complaint when you are dissatisfied with the quality of service or care that the plan or a provider gave you. (Examples: rude customer service; a problem with a network facility or provider; confusing member materials.) If you have a question but not a complaint, please call Customer Service at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331 (TTY: 711).

Our deadline for a grievance
The standard timeframe is 30 calendar days.

What if it has been more than 60 calendar days since the date of service or incident?
You may need to show you have a good reason for filing late. Examples include: you were in the hospital during that time; you got the denial notice too late; an accident caused the records to be destroyed; there was a death or serious illness in your immediate family. Please give your reason on the first page, under "What you can do if your 60-calendar-day deadline has passed."

What to include under "Information about your issue"
Please tell us about the issue. Include dates, locations and claim numbers, if you know them.

- What have you already tried to resolve the issue? Include dates if you know them. This will help us research your issue.
- Tell us what resolution you would like to see. (Examples: get a refund of my out-of-pocket medical expense; have management to be aware of my complaint; cover my prescription drug.)
- If your date of service or date of incident was more than 60 calendar days ago, please tell us why you didn't file within 60 calendar days. You'll need to have a good cause. (For examples, see "What if it has been more than 60-calendar-days since the date of service or incident?")

Please include any other information with this form that you would like to provide to help us research your appeal or grievance. If you use extra pages, be sure to mail or fax them to us with this form.

Questions?

Please contact our Member Services number at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., Monday - Friday from April 1 to September 30; and 7 days a week from October 1 to March 31.

Comuníquese con nuestro Departamento de Servicio al Cliente al 480-937-0409 (en Arizona) o al número gratuito 1-800-446-8331 para obtener información adicional. Los usuarios de TTY deben llamar al 711. El horario de atención es de 8:00 a.m. a 8:00 p.m., lunes a viernes desde el 1 de abril hasta el 30 de septiembre; y los 7 días de la semana desde el 1 de octubre hasta el 31 de marzo.