

BCN AdvantageSM



Blue Care
Network
of Michigan

Medicare and more

A nonprofit corporation and independent licensee of the
Blue Cross and Blue Shield Association

Member Request for Appeal or Grievance

Member name _____ Contract number _____

Member date of birth _____ Daytime phone _____

Please summarize your complaint. (Give a brief description of the situation, your condition and medical treatment, if applicable. If you need more space for your summary, please attach an additional sheet to this form.)

Please fill out this table about the physicians seen for the condition above:

Physician(s) name and telephone number(s)	Date(s) of services	Type of service (surgery, ER visit, prescription drug, etc)	Billed amount (if any)

Return to:

BCN Advantage Grievance and Appeals Unit – Mail Code C248
Blue Care Network
PO Box 5043
Southfield, MI 48086-5043
Fax# 1-888-458-0716

Authorization for Release of Medical Records to BCN Advantage

I authorize the release of any health or medical information and medical records regarding this request to BCN for the purpose of conducting an internal or external review with the following limitations (check if applicable):

_____ Release only records for the time period of ____/____/____ to ____/____/____

_____ Do not release the following information (describe dates of treatment, diagnosis, physician name)

Signature of member or authorized representative: _____

Date: _____

Additional Consent

I specifically agree to BCN Advantage's release of information relating to the following diagnosis and/or treatment if such information is contained in the records in the possession of BCN: substance abuse (including alcoholism), mental health counseling, AIDS, ARC or HIV testing/treatment.

Signature of member or authorized representative: _____

Date: _____

Authorization of a member representative (if applicable)

I authorize _____ to represent me in this appeal/grievance and all related matters.

Signature of member: _____ Date: _____

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