CareFirst Community Health Plan Maryland

Appeals and Grievances Form

Submission for: ◯ Filing a Pre-Service Appeal (a prior authorization denial) ◯ Filing a Post-Service Appeal (a claim denial)
◯ Filing a Grievance

MEMBER INSTRUCTIONS

Form must be filled out in its entirety.

Use this form when you don't agree with a decision we made about your health care (an appeal) or if you want to tell us you have a complaint (grievance). For help with this form, please call us at 1-410-779-9369 or 1-800-730-8530. TTY users please call 711. Our Member Services staff can talk to you Monday to Friday from 8 am to 5 pm.

Reminder: It may take us up to 30 calendar days for a standard (non-expedited) preservice appeal to get back to you. Do you or your doctor think that waiting 30 calendar days could be bad for your health? If yes, please tell us why (you can attach a separate piece of paper if you need more room). ◯ Yes ◯ No

Member Last Name	Member First Name	MI	Today's Date / /
Member ID Number	Date of Birth (D.O.B)		
Member Address			
Phone	Cell	Other	

NON-PROVIDER SUBMITTING ON BEHALF OF A MEMBER INSTRUCTIONS

If you are NOT the CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) member but are filing this on behalf of the CareFirst CHPMD member, complete this section. Unless you are the parent of the member, federal and state laws require us to get official authorization for you to represent the member. If the CareFirst CHPMD member has not signed this document, you need to attach a completed Designation of Personal Representative form; proof of guardianship; or Durable Power of Attorney for Health Care. If you have any questions, contact us at 1-410-779-9369 or 1-800-730-8530. We are open Monday through Friday from 8 a.m. to 5 p.m.

Representative/Requestor/Submitter Name		
Relationship to the Member		
Representative/Requestor/Submitter Address		
Phone	Fax	Other
Signature of Representative/Requestor/Submitter		

PROVIDER INFORMATION		
To be completed by the provider, if the provider is submitting on behalf of the CareFirst CHPMD member. If the denial was based on an administrative reason (like timely filing, billing issues, etc.) please use the Provider Dispute form instead.		
Provider Name	Group Name	
Provider Tax ID	Provider NPI	Authorization Number
Address	City/State	Zip code
Phone	Fax	Other
Claim amount in question $	Claim Date of Service(s)	Claim number(s) if applicable

Note: Please attach a separate sheet of paper for additional claim numbers for processing. If you have any questions, please contact CareFirst CHPMD Provider Services Department at 1-410-779-9359 or toll free at 1-800-730-8543. We are open Monday through Friday between the hours of 8 a.m. to 5 p.m.

Select the type of service to be reviewed:

◯ Office ◯ Outpatient ◯ E/R Emergency Room ◯ Homecare/(DME) Durable Medical Equipment ◯ Inpatient

◯ Radiology ◯ Lab ◯ Other

Reason for Appeal:

Explain exactly what you are requesting CareFirst CHPMD to reconsider or change in our decision. Attach a copy of any supporting documentation for your appeal. **Medical records are required for all clinical reviews.**

Reason for Grievance

Please tell us why you are filing this complaint and attach a copy of any supporting documentation for your grievance:

◯ You don't agree with a decision we made not to cover a service your doctor asked for (appeal)

◯ You have a complaint (grievance). Tell us more (you can attach a separate piece of paper if you need more room)

Please fax the form to the **CareFirst CHPMD** fax (410) 779- 9367 or mail it to:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attention: Appeals & Grievances Department
P.O. Box 915
Owings Mills, MD 21117