Blue Cross
Blue Shield
Blue Care Network
of Michigan

If you have a problem, often it can be resolved with a simple call. Please call your Customer Service Center using the number on the back of your BCN ID card. If you are not able to resolve your concern or issue by calling us, Blue Care Network of Michigan will accept your request for a grievance when the request is submitted within **180 days from the initial denial notification.** If more than 180 days have passed since you were notified, and you still have a question, please call your Customer Service Center using the number on the back of your BCN ID card. Please see the below description of a grievance to be sure you meet the guidelines before filing:

A grievance is a request for BCN to change a decision related to:

a. The availability, delivery, or quality of health care services, including a complaint regarding a denial for a service or a prescription
b. Benefits or claims payment, handling or reimbursements for health care services

SUBSCRIBER/ (MEMBER) INFORMATION			
Subscriber's (Member) Name	BCN Subscriber (Member) ID Number		Date of Birth
Patient Name (if different from subscriber)	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent		Daytime Telephone Number
Mailing Address	City	State Select...	Zip Code

GRIEVANCE REQUEST
Have you already received the service(s)? ☐ Yes ☐ No **If yes, when:**

TELL US WHAT YOUR GRIEVANCE IS ABOUT	
Summarize your grievance. (Give a brief description of your condition and medical treatment)	
Your Signature	Date Signed

Authorization for Release of Medical Records to BCN

<u>If someone other than you is filing out the form, of grieving on your behalf, you must fill this section out giving that person permission to file a grievance on your behalf.</u>

I authorize the release of any health or medical information and medical records regarding this request.

Signature of subscriber (member) or authorized representative: _____Date:_____

Authorization of a member representative (if applicable)

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

Signature of subscriber(member):
_____Date:_____

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You can send this form to Blue Care Network by email or fax. To email it you can send it to bcngrievance@bcbsm.com or by fax to 866-522-7345.

- Please attach any relevant documents or records to support your grievance
- All grievance decisions will be sent to you in writing and will include a detailed explanation of the decision. We will respond to your grievance for a post-service claim within 60 calendar days and a 30 calendar days for a pre-service

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GRIEVANCE PROCESS FAQ

HOW TO RESOLVE YOUR CONCERNS:

Blue Care Network and your primary care physician are interested in your satisfaction with the services and care you receive. If you have a problem relating to your care discuss this with your PCP first. Often your PCP can correct the problem to your satisfaction. You're always welcome to call Customer Service on the back of your card with any question or problem you have. If you're not able to resolve your issue by calling us, we have a formal process that you can use. You have 180 calendar days from the date of discovery of a problem to file either a standard or an expedited grievance regarding a decision by BCN. To submit a standard grievance, you, your attorney, or someone authorized by you in writing, must submit a statement of the problem in writing to the address below or you can obtain a copy of our form by calling the number on the back of your card.

Appeals and Grievance Unit, Blue Care Network
P.O. Box 44200
Detroit, MI 48244
Fax: 1-866-522-7345
Email: BCNGrievance@bcbsm.com

IF YOU ARE A COMMERCIAL GROUP MEMBER:

Step One/Step Two Grievance Process

We'll review your concern at Step One and reply within 15 calendar days for pre-service claims and within 30 calendar days for post-service claims. If you disagree with our Step One decision, you may request a Step Two grievance within 180 calendar days after receiving BCN's decision. We will review your concerns at the Step Two level and notify you of the decision within 15 calendar days for pre-service and 30 calendar days for post-service. The individuals who review the first-level grievance are not the same ones involved in the initial determination. If the grievance is about a clinical issue, we'll send it to an independent medical consultant for review. The consultant will be in the same or similar specialty as the doctor who provided the service. If we deny your grievance, we'll write to you and explain the reasons for the denial and the next steps in the grievance process.

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IF YOU ARE AN INDIVIDUAL MEMBER:

You have the same rights as above except it is a one-step process and your concerns will be reviewed, and a reply will be sent within 30 calendar days for pre-service and 60 days for post-service grievances. The individuals who review the grievance are not the same ones involved in the initial determination. If the grievance is about a clinical issue, we'll send it to an independent medical consultant for review. The consultant will be in the same or similar specialty as the doctor who provided the service. If we deny your grievance, we'll write to you and explain the reasons for the denial and the next steps in the grievance process.

At your request and at no charge to you, we'll provide all documents and records used in making this decision. If we fail to provide a Determination within 30 calendar days for pre-service or 60 calendar days for post-service claims, (plus 10 business days if we ask for additional medical information) from the date we receive the written grievance, you may request an external review through the Department of Insurance and Financial Services (DIFS).

For questions about this appeals rights, or this notice, or for assistance, please contact the number below.

DIFS Office of Rules, Research and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Fax: 1-517-284-8838
Phone: 1-877-999-6442
(by email) DIFS-HealthAppeal@michigan.gov

EXTERNAL REVIEW PROCESS:

Once the internal process has been exhausted you have external rights

INDEPENDENT REVIEW PROCESS:

If the member is enrolled in a self-funded ERISA group plan, the member has the right to an independent review by the Independent Review Organization (IRO). To appeal our decision the member must notify us in writing, and we will randomly assign the review to one of our three contracted IRO's. The decision rendered by the IRO is binding, and we will be responsible for all costs incurred. The member must exhaust this process prior to filing a lawsuit.

Additionally, if we fail to render a decision within 45 calendar days from the date we receive the request, the member may request and independent review by an IRO.

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The request for Independent Review can be mailed to the address below:

Appeals and Grievance Unit, MC A01C
PO Box 44200
Detroit, MI 48244
Telephone: 1-800-662-6667
Fax: 1-866-522-7345

EXTERNAL REVIEW BY DEPTARTMET OF INSURANCE AND FINANCAL SERVICES

Review and Decision by the Department of Insurance and Financial Services

All other group members, if you don't agree with our determination at Step Two or we exceeded the time allowed by law, you will be considered to have exhausted the internal process and may appeal to DIFS no later than 127 calendar days following the receipt of BCN's Step Two Decision.

DIFS Office of General Counsel – Appeals Section

(by mail)
P.O. Box 30220
Lansing, MI 48909-7720
Fax: 1-517-284-8838

(by courier/delivery)
530 W. Allegan Street, 7th Floor
Lansing, MI 48933
Phone: 1-877-999-6442

If you're a member of an Employee Retirement Security Act-qualified group, you have the right to bring a civil action against BCN after completing BCN's internal grievance procedures.

EXPEDITED REVIEW PROCESS FOR ALL MEMBERS:

Expedited review:

Under certain circumstances, if your medical condition would be seriously jeopardized during the time it would take for a standard grievance review, you can request an expedited review. To submit an expedited grievance, you, your attorney, or someone authorized by you may call the customer service number at **1-800-662-6667** or can write or fax to us at the address listed below within 180 calendar days from the date of the discovery of the problem. Please include a statement of the problem along with any supporting documentation in writing to:

Appeals and Grievance Unit, Blue Care Network
P.O. Box 44200
Detroit, MI 48244
Fax: 1-866-522-7345

We'll decide within 72 hours of receiving both your grievance and your physician's confirmation. You may also begin an expedited external review at the same time, provided that your situation meets the definition of urgent under the law or you are receiving an ongoing course of treatment. If you receive an adverse determination, you may request an expedited external review from DIFS within 10 calendar days of receiving our final determination. In some instances, we may waive the requirement to exhaust our internal grievance process.

A member of an ERISA qualified group, upon completion of BCN's internal expedited grievance process, may file suit instead of requesting review by DIFS

External Review by the Department of Insurance and Financial Services

The member (or a person authorized by the member) may request reconsideration of the final determination of BCN by the Department of Insurance and Financial Services within 10 days following the receipt of the final determination at the address below.

DIFS Office of General Counsel – Appeals Section

(by mail)
P.O. Box 30220
Lansing, MI 48909-7720
Fax: 1-517-284-8838

(by courier/delivery)
530 W. Allegan Street, 7th Floor
Lansing, MI 48933
Phone: 1-877-999-6442