Blue Cross Blue Shield of Michigan
Member Appeal Form

Mailing Address:
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., M.C. CS3A
Detroit, MI 48226-2998
FAX: 877-348-2210

Enrollee/Patient Information Section				
Enrollee's Name	Enrollee ID	Group Number		
Patient's Name (if different from enrollee)	Relationship to Enrollee ☐ Self ☐ Spouse ☐ Dependent	Daytime Telephone Number		
Address	City	State	Zip Code	

Claim Detail Section	
Date of Service	Location of Service
Type of Service	Provider Name

To assist us in reviewing your appeal, please summarize the issue and action desired, and attach all supporting documentation.
To qualify for an appeal, we must receive your written request no more than 180 days after you receive the claim denial notice.

Your Signature: _____ Date: _____

If you are the person who received the services and you want someone else to speak on your behalf, please complete the *Designation of Authorized Representative for Appeal* form.

If you are completing this form for someone else, please have him/her complete the *Designation of Authorized Representative for Appeal* form for you to represent him or her on this appeal.

If you are a provider representing a member, you must include a completed and signed Designation of Authorized Representative for Appeal form. If you have not been named an authorized representative and wish to file an appeal as a provider, refer to WebDENIS for the Provider Appeal form.