blue of california

Request for Administrative Review of Complaint

Blue Shield of California Life & Health Insurance Company

Please complete all items on both sides of this form and send it with all necessary attachments to:

Blue Shield of California Life & Health Insurance Company
Administrative Review Section
P.O. Box 1557
Minneapolis, MN 55440-1557

(866) 510-8778

Section 1 – Identification

Insured's last name	First name		MI
Address	City	State	ZIP
Social Security No.	Telephone No. ( )	Policy No.	

Patient's name

Section 2 – Attachments

Please attach any documentation or additional information that may be helpful in reviewing your complaint: for example, the Explanation of Benefits form(s), letters received from Blue Shield Life, itemized bills, additional medical information from your physician, etc.

Have you included attachments? ☐ Yes ☐ No

Section 3 – Identification of problem and statement of complaint

A. Please complete the following items; if the items are not applicable to your complaint write N/A in the spaces.

Provider(s) of services

Charges for services

Description of services

Dates of services

B. Please write a statement completely descrribing your complaint.

(continued on reverse)

An Independent Licensee of the Blue Shield Association ABU1060 (4/07)

Section 3 – Identification of problem and statement of complaint (continued)

(continued)

If additional space is needed, please continue on a separate sheet and attach to this form.

Section 4 – Requested resolution of complaint

Please state what action you wish Blue Shield Life to take with regard to your complaint.

If additional space is needed, please continue on a separate sheet and attach to this form.

Section 5 – Certification and authorization to release information

I authorize these persons having any records or knowledge of me or my health: physician, medical or health care provider, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, employer or plan administrator, government agency, organization or entity administering a benefit program, educational, vocational or rehabilitation organization or program, to give this information: all medical information on me, including medical history, diagnosis, prognosis and treatment of any physical or mental condition, to Blue Shield Life. I understand that Blue Shield Life will use the information to determine my eligibility or entitlement for insurance benefits. I understand I have right of access and correction with respect to all personal information provided under this authorization. Blue Shield Life may release information about me to a reinsurer, a plan administrator, or any person performing business or legal services for blue Shield Life in connection with my claim. I understand and agree that his authorization shall remain in force throughout the duration of my claim for benefits with Blue Shield Life. A photocopy of this authorization is as valid as the original.

Signature of patient (or parent/guardian, if minor)

_____

Name _____ Relationship _____ Date _____

Signature of insured (or parent/guardian, if minor)

_____

Name _____ Relationship _____ Date _____