BLUE SHIELD PROMISE CAL MEDICONNECT WRITTEN APPEAL FORM
PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR CAL MEDICONNECT APPEAL

You have a right to an appeal if you believe you are entitled to a service or benefit that has been denied.

Medicare Part C (Medical Services) ☐	Medicare Part D (Prescription Drugs) ☐
PROCESSING TIME	**PROCESSING TIME**
Standard pre-service = 30 Days	**Standard pre-service = 14 Days**
Standard post-service and all Claims = 60	Standard post-service = 14 Days
Expedited = 72 Hours	Expedited = 72 Hours

An **expedited** appeal is only available when the standard process could seriously jeopardize life, health, or the ability to regain maximum function. Expedited requests not meeting one of these criteria will be transferred to the **standard** process. Please be aware that all claim appeals are processed as standard appeals.

☐ **Request for Standard Appeal** or ☐ **Request for Expedited Appeal**

Member Name: ____________________ **Member ID:** ____________________

Member Address: ____
(Street, City, State, Zip)

Member Phone#: ____________________ Alternate#: ____________________

Provider Name: ____

Provider Mailing Address: ____

Provider Phone#: ____

Please describe what was denied: ____

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Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association A50789 (1/19)

Please describe why you believe you are entitled to the denied service or benefit:

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Member Signature: ____

Name of Person Submitting Appeal: ______________________________________

Signature of Person Submitting Appeal: ____________________________________

Date: ____

PLEASE SUBMIT ANY SUPPORTING DOCUMENTS WITH YOUR APPEAL

HOW TO SUBMIT YOUR MEDICARE APPEAL

Expedited and Standard Medicare Appeals may be requested by submitting this form. However, this form is optional as both Expedited and Standard appeals may also be requested by calling Blue Shield of California Promise Health Plan Cal MediConnect Plan (Medicare-Medicaid Plan).

An enrollee may appoint any individual (such as a relative, friend, advocate or an attorney) to act as his or her representative. To be appointed by an enrollee, both the enrollee making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form or an equivalent written notice. An "equivalent written notice" is one that:

- Includes the name, address, and telephone number of enrollee;
- Includes the enrollee's HICN [or Medicare Identifier (ID) Number];
- Includes the name, address, and telephone number of the individual being appointed;
- Contains a statement that the enrollee is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- Is signed and dated by the enrollee making the appointment; and
- Is signed and dated by the individual being appointed as representative, and is accompanied by a statement that the individual accepts the appointment.

If you require this form, please contact Blue Shield of California Promise Health Plan Cal MediConnect Plan at 1-855-905- 3825 (TTY: 711) from 8:00 a.m. to 8:00 p.m., seven days a week or visit www.blueshieldca.com/promise/calmediconnect.

blue california | Promise Health Plan

Please send your written appeal to:

Blue Shield of California Promise Health Plan (Cal MediConnect Plan) Member Services Department – Appeals
601 Potrero Grande Dr., Monterey Park, CA 91755
Fax: 323-889-5049

If you have any questions, please call our Blue Shield Promise Cal MediConnect Plan Member Services Department at **1-855-905-3825** (TTY: 711) **from 8:00 a.m. to 8:00 p.m., seven days a week.** One of our representatives will be happy to assist you.

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