**HIGHMARK BLUE CROSS BLUE SHIELD (HIGHMARK BCBS)**
**CHP APPEAL REQUEST FORM FOR DENIAL OF SERVICES**

**Mail this form to**:
Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

**Fax this form to: 844-759-5954**

**Today's date**: _____

**Enrollee information**
Name: [First Name] [Last Name]
Address: [Address] [City, State ZIP]
Home phone: [Home Phone]
Plan reference number: [Reference Number]
Service being denied: [SERVICE]

Enrollee ID: [Enrollee ID]

Cellphone: [Cell Phone]

**I think the plan's decision is wrong because**:_____

_____

_____

Check all that apply:
☐ I request a Fast Track Appeal because a delay could harm my health.
☐ I enclosed additional documents for review during the appeal.
☐ I would like to give information in person.
☐ I want someone to ask for a Plan Appeal for me:

- Have you authorized this person with Highmark BCBS before? ☐ YES ☐ NO
- Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. ☐ YES ☐ NO

**Requester (person asking for me)**

Name: _____ Email: _____

Address, City, State, and ZIP: _____

Phone #: (_____) _____ Fax #: (_____)_____

**Enrollee signature:** _____ Date: _____

**Requester signature**: _____ Date: _____

*If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.*

**bcbswny.com/stateplans**