

BCN Advantage<sup>SM</sup>



Blue Care  
Network  
of Michigan

*Medicare and more*

A nonprofit corporation and independent licensee of the  
Blue Cross and Blue Shield Association

### Member Request for Appeal or Grievance

Member name \_\_\_\_\_ Contract number \_\_\_\_\_

Member date of birth \_\_\_\_\_ Daytime phone \_\_\_\_\_

Please summarize your complaint. (Give a brief description of the situation, your condition and medical treatment, if applicable. If you need more space for your summary, please attach an additional sheet to this form.)

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Please fill out this table about the physicians seen for the condition above:

Physician(s) name and telephone number(s)	Date(s) of services	Type of service (surgery, ER visit, prescription drug, etc)	Billed amount (if any)

**Return to:**

BCN Advantage Grievance and Appeals Unit – Mail Code C248  
Blue Care Network  
PO Box 5043  
Southfield, MI 48086-5043  
Fax# 1-888-458-0716

**Authorization for Release of Medical Records to BCN Advantage**

I authorize the release of any health or medical information and medical records regarding this request to BCN for the purpose of conducting an internal or external review with the following limitations (check if applicable):

\_\_\_\_\_ Release only records for the time period of \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Do not release the following information (describe dates of treatment, diagnosis, physician name)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of member or authorized representative: \_\_\_\_\_

Date: \_\_\_\_\_

**Additional Consent**

I specifically agree to BCN Advantage’s release of information relating to the following diagnosis and/or treatment if such information is contained in the records in the possession of BCN: substance abuse (including alcoholism), mental health counseling, AIDS, ARC or HIV testing/treatment.

Signature of member or authorized representative: \_\_\_\_\_

Date: \_\_\_\_\_

**Authorization of a member representative (if applicable)**

I authorize \_\_\_\_\_ to represent me in this appeal/grievance and all related matters.

Signature of member: \_\_\_\_\_ Date: \_\_\_\_\_

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