



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

CUSTOMER CONCERN FORM

Attn: Appeal/Grievance Coordinator
PO Box 1106
Lewiston, Idaho 83501

If you have any questions or need help completing this form, please call us at (208) 746-2671 or 1-800-632-2022

TODAY'S DATE:	IDENTIFICATION NUMBER:
PATIENT NAME:	DATE OF BIRTH:
ADDRESS:	CITY, STATE, ZIP CODE:
PHONE NUMBER:	HIC #:
DATE OF ENROLLMENT:	DATE OF DISENROLLMENT (if applicable):
PROVIDER/PHYSICIAN INVOLVED:	DATE(S) OF SERVICE:
CLAIM NUMBERS (if applicable):	

I give my permission to notify the provider of this concern. I understand that my name and a description of the concern will be given to the provider in writing or through discussion regarding the circumstances to aid the provider in their continual improvement efforts.

Please explain the concern or reason for appeal in space provided on the back.

I hereby authorize Regence BlueShield of Idaho to get any medical records needed to answer my Appeal/Concern request. This includes the release of information about alcohol or drug abuse, and mental health if applicable. This authorization begins on the date shown below and remains in effect so long as my case is being reviewed.

Signature of Patient or Authorized Representative
(Patient's Parent/Guardian may sign if patient is a minor child)

Today's Date

If the patient is unable sign this authorization due to a physical or mental disability, please attach copies of legal documents showing your power to act on the patient's behalf. If the patient is capable of signing but wishes to appoint an Authorized Representative, the patient must complete the back of this form.

CLAIMS DENIAL

PREAUTHORIZATION DENIAL

CONCERN

