BlueCross BlueShield of North Carolina
PO Box 30055
Durham, NC 27702-3055

North Carolina State Health Plan
for Teachers and State Employees
www.shpnc.org

PPO Appeal Form

YOUR INFORMATION

NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	

SUBSCRIBER INFORMATION

SUBSCRIBER	SUBSCRIBER ID NUMBER
PATIENT	DATE OF SERVICE / /
HOSPITAL	DOCTOR
INQUIRY NUMBER	DATE FORM MAILED / /

You have the right to appeal. In order to start this process, this form must be completed in its entirety, signed and dated, and submitted for review within 180 days of notification of the Date of Denial. Please attach copies of all documentation you may have in relation to this appeal and include any additional information which may support your Appeal.

This form and information may be submitted to:

Member Rights and Appeals Level 1
Blue Cross and Blue Shield of North Carolina
PO Box 30055
Durham, NC 27702-3055

In accordance with Blue Cross and Blue Shield of North Carolina (BCBSNC) policies, all information contained herein or attached is subjected to review by any BCBSNC staff member as is appropriate.

REASON FOR APPEAL (If additional space is needed, please use the back of this form and/or attach additional sheets as needed.)

Signature: _____ Date: _____

An independent licensee of Blue Cross and Blue Shield of North Carolina

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Signature: _____ Date: _____