Florida Blue

In the pursuit of health®

Mail to:
Florida Blue Health
Plan Appeals
P.O. Box 44197
Jacksonville, FL 32231-4197

Health Plan Grievance and Appeal Form

I understand that in order for Florida Blue to review my appeal, they may need medical or other records or information relevant to my appeal. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me or my dependents to release such information to Florida Blue in order for them to complete the review of my appeal. These persons or entities may include any:

1. Licensed physician
2. Medical practitioner
3. Hospital
4. Clinic or other medical or medically-related provider
5. Insurer
6. Employer
7. Other organization, institution or person

I specifically authorize the release of the following records or information if pertinent to my appeal: Any and all medical records and information about, associated with or with reference to:

1. A positive test result for HIV infection
2. ARC
3. AIDS
4. Alcohol or drug dependency
5. Mental and nervous disorders

For help, please call the customer service number on back of your member ID card.

Date:	Individual's Signature:
PLEASE PRINT CLEARLY AND COMPLETE ALL OF THE INFORMATION REQUESTED BELOW	
Patient's Last Name:	Patient's First Name:
Date of Birth:	Member/Contract Number (letters and numbers):
Street Address:	State and Zip Code:
Phone Number:	Employer (if applicable):
Group/Plan Number on ID Card:	Claim Number (If available):
Date of Service Being Appealed (Use additional sheets, if necessary):	
Condition/Diagnosis (Use additional sheets, if necessary):	
Please describe the nature of your grievance and any facts you feel should be considered in the review of your grievance. Use additional sheet(s) if necessary. If the problem involves unpaid bills, please attach a copy of the bill(s) or a completed claim form.	

Note: Correspondence will be sent directly to the benefit address we have on file for the member referenced in the appeal.

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