

YOUR APPEAL RIGHTS AND APPEAL FORM



If you receive your health benefits coverage through an employer-sponsored plan and your employer is not a governmental entity or religious organization, your claim appeal rights are likely governed by the Employee Retirement Income Security Act ("ERISA"). If you receive your health benefits coverage through any other arrangement, you have the same appeal rights as a matter of contract.

To appeal a claim that has been denied in whole or in part for which you have financial responsibility you must do the following:

1. Make your appeal **in writing** by circling the claim (on the reverse side of this form) that you want to appeal.
2. Tell us why you disagree with the denial: _____

3. You have the right to documents used in making the claim determination including any guidelines or rules referred to in the denial. The documents are available free of charge. Tell us what documents you want in order to assist you with your appeal.
4. List any documents you have attached for consideration in your appeal: _____

5. If you have authorized someone else to make this appeal on your behalf, you must give us the following information:
Authorized Person's Name: _____
Address for mailing notices _____

Fax Number () _____
Telephone Number () _____
6. BCBSKS must receive your first level appeal within 180 days of the adverse decision. BCBSKS must make an initial appeal determination within 30 days of receiving your written appeal. You also have the right to a second level of appeal if BCBSKS receives the written request on appeal within 90 days of the first appeal determination. BCBSKS must make the second appeal determination within 30 days of receiving your written request for second level appeal.

If you are covered by one of these health benefit plans identified above as subject to ERISA, you also have the right to pursue judicial review under Section 502(a) of ERISA if you are still dissatisfied with a claim denial after exhausting your ERISA appeal procedures. You may file for judicial review pursuant to ERISA in Federal or State court.

(Signature) _____ (Date) _____

Identification Number _____
Telephone Number () _____
Fax Number () _____

Mail your appeal to the address shown on the reverse of this form. If you have questions about your claim or about appeal procedures please call one of the telephone numbers listed on the reverse of this form.

Other Information:

APPLICABLE TO ADMINISTRATIVE SERVICES ONLY GROUPS: For some contracts, Blue Cross and Blue Shield of Kansas provides administrative claims payment only and does not assume any financial risk or obligation with respect to claims. Please consult your contract, certificate, or benefit description to determine whether this applies to you.