



# BlueCross BlueShield of Montana

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association

## MEMBER APPEAL FORM

Your appeal must be received within the required time frame. Review the time limitations listed on the back of your Explanation of Benefits prior to submitting your appeal.

Policyholder:	Health Plan ID:
Employer Name: (If applicable)	Phone #:
Date(s) of Service<	
Patient(s) Name(s):	
Provider(s) Name(s):	
Claim Number(s):	

**\*\*Signature (Patient or Authorized Representative):**

\*Appeal: What are you appealing?

Why are you appealing?

What is your expected outcome?

\*\*\*Please include any supporting documentation if applicable.

Appeals Team  
Blue Cross and Blue Shield of Montana  
P.O. Box 4309  
Helena, Montana 59604

Fax 406-441-3089

If you have any questions, please contact Customer Service at 800-447-7828.