Florida Blue
In the pursuit of health®

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

Non-HMO Health Plan Appeal Form

(For use with BlueOptions, BlueChoice, BlueSelect, GoBlue or Traditional plans (not HMO)

I understand that in order for Florida Blue to review my appeal, Florida Blue 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 Florida Blue to complete its 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 questions, please call the Customer Service number on your member ID card.

Date:	Individual's Signature:

PLEASE PRINT CLEARLY AND COMPLETE ALL OF THE INFORMATION REQUESTED BELOW:

Individual's Name:	ID Card Number:

Address:

Phone Number:	Employer (if any):

Group/Plan Number on ID Card:

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.