BlueCross BlueShield of Tennessee

Member Grievance Form

To: Member Grievance Committee
P.O. Box 180198
Chattanooga, Tennessee 37402

From: Patient's Name _____
Identification Number: _____
Address: _____
_____
Telephone: _____

Date of Service: _____
Provider: _____
Amount of Bill: _____
Claim No.: _____

Note: It is your responsibility to supply any pertinent medical records or other information necessary to support your request. Enclose any such documentation along with this form and mail to the address above. Please check the appropriate box below to indicate whether such documents are enclosed with your grievance.

- ☐ Enclosed please find all medical records and/or other information pertinent to my grievance.
- ☐ No medical records or additional information are enclosed or needed to support this grievance.

Please describe your complaint (you may continue onto the back of this form or attach additional pages if needed):

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I do hereby authorize any physician, nurse, hospital or provider of medical services to furnish BlueCross BlueShield of Tennessee, Inc. any and all medical, admission and insurance records pertaining to me or the member referenced above.

Signature: _____ Date: _____

COMM-PPO-97 (8/02)

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