Request for a Reconsideration (Appeal) Form for Inpatient and/or Outpatient Services

CareFirst Medicare Advantage

A. MEMBER INFORMATION		
Member ID Number:	Telephone No:	
Last Name:	First:	MI:
Street Address:		
City:	State/Zip Code:	Date of Birth:

B. APPELLANT INFORMATION		
Person Appealing: ◯ Beneficiary ◯ Provider ◯ Authorized Representative		
Last Name:	First:	MI:
Street Address:		
City:	State/Zip Code:	Relationship to Member:

C. APPEAL INFORMATION
Date the Item or Service was Provided:
Date of the Initial Determination Notice (please include a copy of the notice with this request): *(If you received your initial determination notice more than 60 days ago, include your reason for the late filing.)*
I do not agree with the determination decision on my claim because:

C. APPEAL INFORMATION
Additional Information CareFirst BlueCross BlueShield Medicare Advantage should consider:
◯ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. ◯ I do not have evidence to submit.

Signature:	Date:

Authorized Representatives must complete an Authorized Representative form and submit it with this appeal form or have one on record with the health plan.

Mail or Fax this Request to:

CareFirst BlueCross BlueShield Medicare Advantage
Attention: Appeals & Grievance Department
P.O. Box 915
Owings Mills, Maryland 21117

Fax: 1-844-405-2158

CareFirst BlueCross BlueShield Medicare Advantage is a HMO-SNP plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Medicare Advantage depends on contract renewal.

CareFirst BlueCross BlueShield Medicare Advantage complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-386-6762 (TTY: 711).

.注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-262-1122 (TTY: 711).