BlueCross BlueShield of Montana

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 866-589-8256

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