



## Member Appeal Request Form

**Instructions:** Please complete this form and attach any documents that will help us understand your appeal request.

Mail to: **Anthem Blue Cross and Blue Shield  
Member Appeals and Grievances  
P.O. Box 62429  
Virginia Beach, VA 23466**

You may also ask for an appeal by phone. Just call the phone number printed on your member ID card. We'll send you a response within 30 calendar days of when we receive this form.

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Date: \_\_\_\_\_

Member name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Information about the appeal

We will use the information you provide below to evaluate your appeal. This will be included as part of the permanent appeal record. Please write clearly and legibly. Use more sheets of paper if needed.

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Date of service: \_\_\_\_\_

Type of service: \_\_\_\_\_

Outcome desired: \_\_\_\_\_

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**X** \_\_\_\_\_ Date \_\_\_\_\_  
Signature of member  
(Parent or guardian if the member is a minor)

If the appellant is physically unable to sign, I, the Authorized Representative, certify that (appellant) \_\_\_\_\_ is physically unable to sign this form.

Describe the incapacity affecting the appellant.

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Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Authorized Rep (printed) name \_\_\_\_\_  
First Last

**[anthem.com/inmedicaid](https://www.anthem.com/inmedicaid)**

Serving Hoosier Healthwise, Healthy Indiana Plan,  
Hoosier Care Connect, and  
Indiana PathWays for Aging

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