BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

PPO Group Plan Appeal Form
(for use by Covered Persons)

Please mail directly to:

PPO Appeals
PO Box 44197
Jacksonville, FL 32231-4197

I HEREBY request a review of the adverse benefit determination described below and understand the receipt of this form by Blue Cross and Blue Shield of Florida (BCBSF) constitutes a formal appeal.

If you have any questions, please feel free to call the customer service number located on your ID card.

Date:	Individual's Signature:

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

Individuals 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 reason for your appeal and any facts you feel should be considered in the review of your appeal. If the problem involves unpaid bills, please attach a copy of the bill(s): (Use additional sheet(s), if necessary.)	

Note: Correspondence will be sent directly to the benefits address we have on file for the member referenced in the appeal.