Regence

Contact the phone number on the back of your member identification card for assistance with filling out this form.

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

APPEAL FORM

Please return completed form to:

Commercial and Individual
Regence BlueShield
Attn: Regence Level 1 Member Appeals
PO Box 1106
Lewiston, ID 83501-1106
or via fax at 1 (888) 496-1542
Email: MemberAppeals@regence.com

Self-Funded Groups (ASO)
Attn: ASO Member Appeals
Regence BlueShield
PO Box 1106
Lewiston, ID 83501-1106
or via fax at 1 (877) 663-7526
Email: MemberAppeals@regence.com

Medicare Advantage appeal forms are available at www.regence.com/medicare/grievances-appeals.

Patient Name	Date of Birth (mm/dd/yyyy)	Phone Number (xxx) xxx-xxxx
Address	City, State, ZIP Code	E-Mail Address (optional) Email address
Identification Number (numerics only, without alpha prefix)	Group Number	Today's Date (mm/dd/yyyy)
Doctor/Hospital Name	Date(s) of Service or Incident	
Claim Numbers (if available)		

Note: If you are initiating an appeal on behalf of another person who is not a minor, Regence BlueShield (Regence) must also receive a completed HIPAA authorization form, signed by that person, which can be found on the regence.com website.

Please explain the problem. Include background, time frames, and the names of anyone else you have spoken with to try and resolve the problem, any supporting documentation, and your expectations or suggestions for resolution.

List any supporting documentation attached to this form:

We need your permission to authorize Regence to request any medical records needed to answer your appeal. This includes information about alcohol or drug abuse, mental health, AIDS or HIV virus, if applicable. This authorization begins today and remains in effect so long as your appeal is being reviewed. You will receive an acknowledgment letter for this appeal with information about the appeals process.

PRINTED NAME

RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE *
(Patient's parent/guardian may sign if patient is a minor child)

(mm/dd/yyyy)
TODAY'S DATE

THIS SECTION TO BE COMPLETED BY OFFICE STAFF	Did the member fax or mail in supporting documentation? Check box if Yes ☐ Did the member provide this authorization verbally? Check box if Yes ☐

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