Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Member Appeal Request Form

If you got a Notice of Adverse Benefit Determination or denial from us and you disagree with it, you may ask for an appeal. You must do this within 60 days from the date on the denial. You may ask for an appeal by calling or writing us. To appeal in writing, fill out this form or write us a letter. Send it to the address or fax number below. We will send you a letter with our decision within 30 calendar days from the date we get your appeal.

Mail it to: Attn: Appeals
Healthy Blue
P.O. Box 100215
Columbia, SC 29202-3215

or fax it to 803-870-6505.

Instructions: Please fill out sections 1 and 2. Attach any paperwork you want us to review. Sections 3 and 4 are optional.

Section 1: Member Information

Last name | First name | Middle initial

Date of birth | Phone number | Healthy Blue Medicaid ID number

Email address (optional) | Today's date

Street address

City, state and ZIP code

I am asking for an expedited (fast) appeal: ☐ Yes ☐ No

Section 2: Appeal Information

I am filing this appeal because Healthy Blue:

☐ Will not pay for a medical or pharmacy service I received.
☐ Will not say it is OK for me to get a medical or pharmacy service.
☐ Stopped paying for a medical or pharmacy service I was receiving.
☐ Took too long to decide if it would pay for a medical or pharmacy service.

Section 3: Representative Information (Optional)

A representative is not required. However, you may choose anyone you wish to help you file an appeal, including a family member, doctor or attorney. If you want a representative to help you file this appeal, complete this section.

Note: If you complete this section, you do not need to complete the separate Member Appeal Representative Form.

Representative's last name | Representative's first name | Representative's middle initial

Representative's phone number | Representative's street address

Representative's city, state and ZIP code

Member signature | Date

Section 4: Additional Information (Optional)

Please write any additional information you feel may be helpful with your appeal request. Tell us why you are appealing and why you disagree with our decision. Please give us the names of any providers who may have records about the service in question.

This information becomes part of the permanent record. Please write clearly. Use extra paper if needed.

If you need help with this form, call Customer Service at 866-781-5094 (TTY: 866-773-9634) Monday - Friday, 8 a.m. - 6 p.m.