

PO Box 30055 Durham, NC 27702-3055

## North Carolina State Health Plan for Teachers and State Employees

www.shpnc.org

## **PPO Appeal Form**

YOUR INFORMATION					
NAME					
STREET ADDRESS					
CITY		STATE	ZIP CODE		
HOME TELEPHONE NUMBER	WORK TELEPHON	IE NUMBER			
SUBSCRIBER INFORMATION					
SUBSCRIBER	SUBSCRIBER ID N				
PATIENT		DATE OF SERVICE	/	/	
HOSPITAL	DOCTOR				
INQUIRY NUMBER		DATE FORM MAILED	/	/	
You have the right to appeal. In order to start this process, this form must be completed in its entirety, signed and dated, and submitted for review within 180 days of notification of the Date of Denial. Please attach copies of all documentation you may have in relation to this appeal and include any additional information which may support your Appeal.					
This form and information may be submitted to:					
Member Rights and Appeals Level 1 Blue Cross and Blue Shield of North Carolina PO Box 30055 Durham, NC 27702-3055					
In accordance with Blue Cross and Blue Shield of North Carolina (BCBSNC) policies, all information contained herein or attached is subjected to review by any BCBSNC staff member as is appropriate. <b>REASON FOR APPEAL</b> (If additional space is needed, please use the back of this form and/or attach additional sheets as needed.)					
Signature:		Date: _			

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Signature:	Date: