BlueCross BlueShield of Montana

# REQUEST FOR APPEAL OF COVERAGE DECLINATION

Check one:

☐ I _____ am age 15 or older and wish to appeal BCBSMT's decision to decline my application for coverage. I believe that BCBSMT erred in declining my application for coverage for the following reasons:

☐ I _____ wish to appeal BCBSMT's decision to decline my application for coverage for my underage (under age 15) dependent _____. I believe that BCBSMT erred in declining my dependents' application for coverage for the following reasons:

_____

_____

_____

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_____

[Attach additional sheets if needed.]

With this request I am submitting the following documentation that was available prior to submission of my application:

- ☐ Complete medical records from _____(provider name).
- ☐ Results of specific testing and/or treatment.
- ☐ Office Notes from my care provider regarding the health concerns addressed in my declination letter.
- ☐ Other

I understand that if BCBSMT reverses its decision and offers me or my dependent(s), as applicable, the coverage I originally applied for, that coverage will be made effective as of the originally requested effective date. I further understand that I will be required to pay all premiums that have accrued since that date in order for the coverage to become effective.

_____ _____

Signature Date

_____ _____

Parent/Guardian Signature (if appellant is under 15) Date