

MEMBER APPEAL REPRESENTATIVE FORM

Member Name: _____

Member Address: _____

City, State, ZIP: _____

I choose the following person to act on my behalf and represent me in my appeal process with Healthy Blue: _____

(Name of Representative)

Member Signature: _____

Date: _____

Please send to:

**Healthy Blue
Appeal and Grievance Department
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax number 1-866-216-3482**

If you fax this form, you also must mail the one you filled out to the Appeals Department at the address listed above.

www.HealthyBlueSC.com

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Language Services

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-866-781-5094 (TTY 1-866-773-9634).

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-866-781-5094 (TTY 1-866-773-9634).

هل تحتاج إلى مساعدة في رعايتك الصحية أو في التحدث معنا أو قراءة ما نقوم بإرساله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى بدون تكلفة عليك. اتصل بنا على الرقم المجاني 1-866-781-5094 (TTY 1-866-773-9634).