of Tennessee

Tennessee Valley Authority
Member Grievance Form
****Confidential****

To: BlueCross BlueShield of Tennessee
Commercial Member Grievance
1 Cameron Hill Circle Ste 0019
Chattanooga, TN 37402-0019

From: Patient's Name:_____

Identification Number: _____

Address:_____

_____

Telephone:_____

Date of Service: _____

Provider:_____

Amount of Bill: _____

Claim No.: _____

Note: It is your responsibility to supply any pertinent medical records or other information necessary to support your request. Enclose any such documentation along with this form and mail to the address above. Please check the appropriate box below to indicate whether such documents are enclosed with your grievance.

- ❑ Enclosed please find all medical records and/or other information pertinent to my grievance.
- ❑ No medical records or additional information are enclosed or needed to support this grievance.

Please describe your complaint (you may continue onto the back of this form or attach additional pages if needed):

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I do hereby authorize any physician, nurse, hospital or provider of medical services to furnish BlueCross BlueShield of Tennessee, Inc. any and all medical, admission and insurance records pertaining to me or the member referenced above.

Signature: _____ Date: _____