BlueCross BlueShield of Texas

TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services

REQUEST FOR FAIR HEARING

Member Name: _____

Member Address: _____

Member Phone Number: _____

Member Email Address: _____

Member Medicaid Number: _____

Plan Name: _____

Service Denied: _____

Date Service Denied: _____

Yes, I would like to request a fair hearing from the Texas Health and Human Services Commission. I have attached a copy of the notification letter.

_____ _____

Member Signature Date

Mail or Fax this form to:

Blue Cross and Blue Shield of Texas
C/O Complaints and Appeals Department
P.O. Box 660717
Dallas, TX 75266
Fax: 1-855-235-1055