Standard

Member Appeal and Grievance Process

Carefully read the information in this packet and keep it for future reference. It has important information about how to appeal/grieve decisions Blue Cross Blue Shield of Arizona (BCBSAZ) makes about your health coverage.

Decisions You Can Appeal or Grieve

STANDARD APPEAL

Denials of Medical Necessity, Contract Coverage, Investigational services

EXPEDITED APPEAL

When your provider certifies that your condition is urgent and services have not been received

MEMBER GRIEVANCE

Disputes about Member Cost share and Plan Allowed Amount

A denial or partial denial occurs when BCBSAZ, as issuer of your health benefit plan ("plan"), makes any of the following decisions:

- Denies your request for pre-certification of a service you haven't yet received;
- Denies a claim for services already received;
- Denies, reduces, or terminates your plan benefits;
- Finds you responsible for payment of cost share (copay, deductible, coinsurance, access fee, balance bill) for a plan benefit;
- Finds that a service is not medically necessary; finds that a service is not covered because it is experimental or investigational;
- Determines that you are not eligible for coverage under the benefit plan; or
- Rescinds your coverage under the plan

The timeframe to dispute a decision you disagree with:

- If we denied a claim or a pre-certification for a service, you have 2 years from the date of denial to request an appeal.
- If you disagree with how we paid the claim (i.e., copay, deductible, coinsurance, level of benefits, etc.), you have 1 year from the date of the notice to file a grievance. (When your dispute is about how we applied cost share, we call it a "grievance".)

Written Notification of Denial

When we make a denial decision, we send you written notice in the form of

1. An “Explanation of Benefits” (EOB) document,
2. A monthly member health statement, or
3. A letter

All of these documents include information about your right to appeal or grieve the decision.

BCBSAZ also contracts with independent third parties to administer some benefits for services which can include:

- Chiropractic services (handled by the Chiropractic Benefits Administrator or the “CBA”),
- Vision hardware (handled by the Vision Hardware Administrator or the “VHA”).

These and other vendors may issue some of these decisions and may perform the review at one or more levels. References in this brochure to BCBSAZ will include the CBA, VHA, and any other vendors when they are administering benefits for BCBSAZ.

Description of the Appeal and Grievance Processes

1. You have the right to file an appeal or grievance, free of charge.
2. Information on where to file an appeal or grievance is included in the written denial notice, (Your Explanation of Benefits statement (EOB), your monthly health statement, or a denial letter.) Your notice will tell you:
    a. Who made the precertification decision or processed your claim (BCBSAZ or a vendor).
    b. Where to file the appeal.

Refer to your benefit book for additional information

1. We cannot change the scope of your coverage or rewrite your cost share amount.
2. We provide a full and fair review of any submitted documents.
3. Standardized forms are found at the back of this brochure but are not required.
4. Consumer assistance is available from the Arizona Department of Insurance (ADOI).

STANDARD APPEALS

First Level – Initial Internal Appeal

1. You have 2 years from the date of the decision to file an appeal.

2. You and your provider should send us any information you want us to consider in the appeal.

3. Be sure to include at least the following information in your request:
    - The decision or action you disagree with and wish to appeal
    - Why you think our original decision is wrong
    - What you are asking BCBSAZ to do differently, and
    - Any medical records that support your request
    - There are forms at the end of this packet that you or your provider can use, but they are not required forms

Remember to include everything you want us to consider in your appeal

4. For issues involving medical judgment, the review is performed by a health care professional who has the appropriate training and experience in the field of medicine involved in the case.

5. The reviewer is someone who was not involved in the original denial decision and is not compensated, rewarded or promoted for upholding the original decision.

6. See end of brochure for the list of addresses where you can send your appeal. This information will also be in your decision notice.

7. BCBSAZ acknowledges the receipt of your appeal within 5 business days and sends a written decision within 30 days.

8. You may have a second level of appeal. The process varies depending on whether you have group or individual coverage and whether your plan is grandfathered or non-grandfathered. Your benefit book shows whether your plan is a grandfathered plan.

Second Level - Voluntary Internal Appeal

Second level internal appeals are available only for members of Group Plans and Grandfathered Individual Plans. Members of non-grandfathered Individual Plans go directly to an External Independent Review.

1. What is a “Voluntary” second level standard appeal?
    - You are not required to file a second level internal appeal, you may skip the second internal review and request an external review.
    - Regardless of whether you choose to participate in this voluntary second level appeal, BCBSAZ waives any claim that you have failed to exhaust administrative remedies.
    - Any statute of limitations defense or other defenses based on timeliness are stopped while your voluntary appeal is pending.
    - The voluntary appeal is free.
    - Before deciding to submit your appeal to this voluntary second level, you also have the right to ask

BCBSAZ for more information about what happens at this level.

- If you want this information, please call or write to BCBSAZ at the address and telephone number on page 12.

2. If your appeal is eligible for external review, BCBSAZ may skip the level 2 and send to an external review with an independent review organization (IRO).

3. You have 60 days to send a written request for a Level 2 review after receiving the Level 1 denial determination.

4. BCBSAZ sends a Level 2 decision to you and your provider:
   - Related to precertification denials within 30 days of receiving your request
   - Related to claim denials for services already provided within 60 day of receiving your request.

Standard External Review

1. If you still disagree with the decision, and the case involves questions of medical judgment or a rescission of coverage the case can be sent for an external independent medical review.
   a. Cases based on "medical judgment" include:
      i. Medical necessity
      ii. Medical appropriateness
      iii. Health care setting
      iv. Level of care
      v. Benefit effectiveness
      vi. Investigational or experimental treatment

Be sure to include any new information you want considered in your appeal

2. You may also appeal contract benefit denials. The Arizona Department of Insurance decides contract coverage appeals.

3. External review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.

4. You have **up to 4 months** from the date of the final internal review decision to submit a written request for external review.

5. After getting your request, BCBSAZ has 5 business days to decide if your request is eligible for external review.
   - BCBSAZ notifies you within one additional business day if your case is not eligible for external review or if your submission is incomplete.
   - If your submission is incomplete, you have up to the 4 month period to submit any missing information.
   - If the time has expired, you have 48 hours after you received BCBSAZ's notice of incomplete submission to send the missing information.

6. BCBSAZ sends the external review to the Arizona Department of Insurance (ADOI). The ADOI decides contact coverage cases and refers medical necessity cases and issues of medical judgment to an external Independent Review Organization (IRO).

STANDARD External Review Appeals Submitted to the ADOI

1. The time periods for a Medical Necessity Case or a case involving issues of medical judgment:
    a. Within 5 business days of receiving the appeal from BCBSAZ, the ADOI sends all of the information to an external IRO.

    b. The IRO has 21 days to make a decision and send it to the ADOI.

    c. The ADOI must mail the IRO's decision to you, your treating provider and to BCBSAZ within 5 business days.

2. The time periods for a Contract Coverage Case:
    a. Within 15 business days of receiving the appeal from BCBSAZ the ADOI:
        - Must decide if the service is covered, and,
        - Send its decision to you, your treating provider and BCBSAZ.

    b. If the ADOI thinks your contract coverage case also involves medical issues, it will send your case to an IRO. If so:
        - The IRO has 21 days to make a decision and send to the ADOI.
        - The ADOI has 5 days business days to send the decision to you, your treating provider and BCBSAZ.

3. If the ADOI or IRO reverses or modifies the decision in your favor:
    a. BCBSAZ complies with the decision.

    b. For cases involving medical issues heard by the IRO, the decision is final, but subject to judicial review.

    c. For contract coverage cases decided by the ADOI, if you disagree with the final decision, you may ask for a hearing with the Office of Administrative Hearings (OAH).

    d. If BCBSAZ disagrees with the ADOI's final decision on a contract case, it may also request a hearing before OAH.
        - BCBSAZ authorizes the service while the OAH hearing is pending.

    e. A party must request the OAH hearing within 30 days of the ADOI's decision.
        - OAH promptly schedules and completes a hearing.

EXPEDITED APPEALS

Denial for urgent services not yet received

If your treating provider certifies that the condition qualifies as urgent, then BCBSAZ treats the appeal as expedited.

A service is urgently needed when the time period for a standard appeal could seriously jeopardize a member's life, health, or ability to regain maximum function, cause a significant negative change in the member's medical condition at issue or subject the member to severe pain that cannot be managed without the requested service.

First Level – Initial Expedited Appeal

1. You and your provider should promptly file your request for expedited appeal. Make sure to send us any information you want us to consider in the appeal.

2. Be sure to include at least the following information in your request:
    - The decision or action you disagree with and wish to appeal
    - Why you think our original decision is wrong
    - What you are asking BCBSAZ to do differently, and
    - Any medical records that support your request
    - There are forms at the end of this packet that you or your provider can use, but they are not required forms

Remember to include everything you want us to consider in your expedited appeal

3. The review is performed by a health care professional who has the appropriate training and experience in the field of medicine involved in the case.

4. The reviewer is someone who was not involved in the original denial decision and is not compensated, rewarded or promoted for upholding the original decision.

5. We have one business day (not to exceed 72 hours) to notify you and your provider of the decision by phone and by mail.

6. See end of brochure for a list of where to send your appeal. This will also be included in the decision notice.

7. You may have a second level of internal appeal if your plan allows. The process varies depending on whether you have group or individual coverage, and whether your plan is grandfathered or non-grandfathered. Your benefit book shows whether your plan is a grandfathered plan.

Second Level - Voluntary Internal Expedited Appeal

Second level internal appeals are available only for members of Group Plans and Grandfathered Individual Plans. Members of non-grandfathered Individual Plans go directly to an External Independent Review.

1. What is a “Voluntary” second level standard appeal?
    - You are not required to file a second level internal appeal, you may skip the second internal review and request an external review.
    - Regardless of whether you choose to participate in this voluntary second level appeal, BCBSAZ waives any claim that you have failed to exhaust administrative remedies.
    - Any statute of limitations defense or other defenses based on timeliness are stopped while your voluntary appeal is pending.
    - The voluntary appeal is free.
    - Before deciding to submit your appeal to this voluntary second level, you also have the right to ask BCBSAZ for more information about what happens at this level.
    - If you want this information, please call or write to BCBSAZ at the address and telephone number on page 12.

2. We have 1 business day (not to exceed 72 hours) to notify you and your provider of the decision by phone and by mail.

Expedited External Review

1. If you still disagree with the decision, and the case involves questions of medical judgment or a rescission of coverage the case can be sent for an external independent medical review.
    a. Cases based on “medical judgment” include:
        1. Medical necessity
        2. Medical appropriateness
        3. Health care setting
        4. Level of care
        5. Benefit effectiveness
        6. Determination that a treatment is investigational or experimental

2. You may also appeal contract benefit denials. The Arizona Department of Insurance hears these appeals.

3. External review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.

4. You have **up to 4 months** from of the date of the final internal review decision to submit a written request for external review.

5. After getting your request, BCBSAZ has 1 business day to decide if your request is eligible for external review.
    - BCBSAZ notifies you within one additional business day, if your case is not eligible for external review or if your submission is incomplete.

- If your submission is incomplete, you have up to the 4 month period to submit any missing information.
- If the time has expired, you have 48 hours after you received BCBSAZ's notice of incomplete submission to send the missing information.

6. BCBSAZ sends the external review to the Arizona Department of Insurance (ADOI) for review. The ADOI decides contract coverage cases and refers medical necessity cases and issues of medical judgment to an external Independent Review Organization (IRO).

EXPEDITED External Review Appeals Submitted to the ADOI

1. The time periods for a Medical Necessity Case or a case involving issues of medical judgment :
    - Within 2 business days of receiving the appeal from BCBSAZ, the ADOI sends all of the information to an external IRO.
    - Within 72 hours of receiving the information, the IRO makes the decision and sends it to the ADOI.
    - Within 1 business day of receiving the IRO's decision, the ADOI mails the notice to you, your treating provider and to BCBSAZ.

2. The time periods for a Contract Coverage Case:

    a. Within 2 business days of receiving the appeal from BCBSAZ the ADOI:
        - Must decide if the service is covered, and
        - Send its decision to you, your treating provider and to BCBSAZ.

    b. If the ADOI thinks your contract coverage case also involves medical issues, it will send your case to an IRO. If so:
        - The IRO has 72 hours to make the decision and send the decision to the ADOI.
        - The ADOI has 1 business day to send the decision to you, your treating provider and to BCBSAZ.

3. If the ADOI or IRO reverses or modifies the decision in your favor:

    a. BCBSAZ complies with the decision.

    b. For cases involving medical issues heard by the IRO, the decision is final but subject to judicial review.

    c. For contract coverage cases decided by the ADOI, if you disagree with the final decision, you may ask for a hearing with the Office of Administrative Hearings (OAH).

    d. If BCBSAZ disagrees with the ADOI's final decision on a contract case, it may also request a hearing before OAH.
        - BCBSAZ authorizes the service while the OAH hearing is pending.

    e. A party must request the OAH hearing within 30 days of the ADOI's decision.
        - OAH promptly schedules and completes a hearing.

MEMBER GRIEVANCES

Appeal Process to Dispute Decisions about Member Cost Share

First Level – Initial Member Grievance

1. You have 1 year from the date of the decision or action to file a grievance.
    a. BCBSAZ has discretion to extend this time limit for good cause:
        - Death in your immediate family
        - Serious illness for either you or someone in your immediate family
2. Timeframes for BCBSAZ to notify you of its decision
    a. Pre-service or precertification issues:
        - Within 30 days from the date BCBSAZ receives your grievance request
    b. Post –Service claims:
        - Within 60 days from the date BCBSAZ receives your grievance request
3. For non-grandfathered Individual Plans, this decision concludes your grievance process. There is no further right to challenge the decision.

Second Level - Voluntary Grievance

1. This level is only available to members of Group Plans and grandfathered Individual Plans

2. What is a “Voluntary” grievance?
    - You are not required to file a second level grievance.
    - Unless your grievance is eligible for external review because it involves a medical judgment, if you skip this voluntary second level grievance, your only other recourse is legal action.
    - Regardless of whether you choose to participate in this voluntary second level grievance, BCBSAZ waives any claim that you have failed to exhaust administrative remedies.
    - Any statute of limitations defense or other defenses based on timeliness are stopped while your voluntary grievance is pending.
    - The voluntary grievance is free.
    - Before deciding to submit your grievance to this voluntary second level, you also have the right to ask BCBSAZ for more information about what happens at this level.
    - If you want this information, please call or write to BCBSAZ at the address and telephone number on page 12.

3. You have 60 days to send a written request for Level 2 after receiving the Level 1 decision.

4. BCBSAZ has 60 days from the receipt date of your Level 2 request to process your grievance.
    a. If the grievance is a pre-service issue, BCBSAZ has 30 days from the date of your request to process your grievance.
    b. BCBSAZ may extend the time limit if necessary and in accordance with applicable law by notifying you in writing including the reason for the extra time.

5. If you still disagree with BCBSAZ’s decision:
    a. For questions about member cost share, that do not involve questions of medical judgment, no further review is available.
    b. You may have other legal recourse to challenge BCBSAZ’s decision in court.

Authorizing someone else to file the appeal or grievance on your behalf

You can designate an "authorized representative" to file an appeal or grievance on your behalf. That person has the right to make decisions about your case (for example, whether to seek review at a higher level, if available). BCBSAZ sends information about the progress of your case to the representative, with a copy to you.

- The following individuals are authorized to appeal or grieve a decision and do not need any special authorization form:
  - Your treating provider acting on your behalf; and
  - A parent on behalf of a minor.

- Also, the following individuals may appeal or grieve a decision for you, if you send BCBSAZ the required proof of authority:

Third Party Representative	Proof of Authority
Member's Legal Guardian	Official copy of the court order appointing the guardian.
Your Agent	Power of Attorney that complies with A.R.S. § 14-5501 (or equivalent statute from other state) authorizing the agent to appeal or grieve a healthcare decision; or Health care power of attorney that complies with A.R.S. § 36-3221 (or equivalent) and authorizes the agent to make health care treatment decisions for you.
Your Surrogate	Someone who qualifies as a surrogate as defined by A.R.S. §36-3231 (or equivalent statute from another state) and Includes a written confirmation from a treating provider that the member is unable to make or communicate health care treatment decisions.
Executor or Personal Representative	Official copies of the death certificate and court order appointing the executor or personal representative
Court Appointed Representative	Adult authorized by any other type of court order to make health care decisions for a member Official copy of the court order

If BCBSAZ receives an appeal or grievance request from a third party who claims to be your authorized representative, including those situations shown above, BCBSAZ may require you to confirm to us in writing the scope of the third party's authorization. We do not recognize the third party's authority until we receive your confirmation.

You cannot use a Confidential Information Release Form (CIRF) to designate an authorized representative to bring forth an appeal/grievance. A CIRF allows us to send your protected health information to someone else, but it is not proof of their authority to act on your behalf.

Medical Records

Under Arizona law (A.R.S. §12-2293), you must request medical records and specify who you want to receive the records. The health care provider who has your records will provide you or your authorized representative with a copy of your records. If you have to obtain medical records from your provider, your provider may have the right to charge you for copies.

If you have an authorized representative, that person can request copies of your medical records. On the written request of a patient or the patient's health care decision maker for access to or copies of the patient's medical records and payment records, the health care provider in possession of the record shall provide access to or copies of the records to the patient or the patient's health care decision maker.

If you reside outside the state of Arizona, the laws that govern medical records and providers in your state may vary.

Confidentiality

If you participate in the appeal or grievance process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to others.

Additional Rights

These appeal and grievance rights are in addition to your rights to challenge the decision in court. For many group plans (other than government plans and church plans), court action may include legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). If you are enrolled in an ERISA qualified group plan, you and your plan may have other voluntary alternative dispute resolution options in addition to these Appeals and Grievance Processes described in your benefit plan booklet, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office. You may also be able to obtain information from your group benefits administrator.

Filing complaint with the Arizona Department of Insurance (ADOI)

Arizona law (A.R.S. §20-2533(F)) requires you to exhaust the appeal process before you file a complaint with the ADOI if your complaint involves a matter that could be appealed. You must pursue the health care appeals process before the ADOI can investigate your complaint.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

If you disagree with how we processed your claim

Call BCBSAZ Customer Service Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays) at these numbers to explain your situation:

Maricopa County (602) 864-4400
Pima County (520) 745-1883
Statewide (800) 232-2345

To Submit an Appeal or Grievance:

For an appeal or grievance call, fax, or write to:	Chiropractor Services (not all plans have the CBA)	Vision Hardware Services (not all plans have the VHA)
BCBSAZ Attn: Medical Appeals & Grievances Specialist P.O. Box 13466 - Mail stop A116 Phoenix, AZ 85002-3466 Phone: (602) 544-4938 or (866) 595-5998 Fax: (602) 544-5601	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509001 San Diego, CA 92150-9001 Phone: (800) 678-9133 Fax: (619) 209-6237	EyeMed Vision Care Attn: Quality Assurance 4000 Luxottica Place Mason OH 45040 Phone: 1-855-855-4816 Fax: 1-513-492-3259

Appeal Resources

BCBSAZ customer service representatives can answer questions about the appeal process and help you with filing an appeal. The BCBSAZ customer service number is (602) 864-4400 or (800) 232-2345 (toll free).

You can also contact the U.S. Department of Labor - Employee Benefits Security Administration at 1-866-444-EBSA (3272). You may also call the Arizona Department of Insurance (ADOI) Consumer Assistance Office at (602) 364-2499 or (800) 325-2548.

Appeal/Grievance Request Form

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

You may use this form to tell BCBSAZ you want to appeal or grieve a decision.

Member Name _____

Member ID # _____

Name of representative pursuing appeal, if different than above _____

Phone # _____

Mailing Address _____

City, State, Zip Code _____

Type of Appeal/Grievance ☐ **Denied Claim** ☐ **Denied Service Not Yet Received** ☐ **Cost Share Dispute**

Claim # (if applicable) _____ **Date of Service** _____

If you are appealing BCBSAZ's decision to deny a service you have not yet received, could a 30 to 60 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function, cause a significant negative change in your medical condition, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider can send us the attached certification and documentation supporting the need for an expedited appeal.

What action or decision are you disputing? _____

Explain why you believe the decision or action was wrong and what you would like BCBSAZ to do differently:

_____

_____

_____

(Attach additional sheets of paper, if needed)

If you have questions about the appeal or grievances process or need help to prepare your request, please call BCBSAZ at (602) 864-4400 or (800) 232-2345.

Make sure that everything that shows why you believe BCBSAZ should process your claim differently or authorize a service, including: ☐ Medical Records ☐ Supporting Documentation (letter from your doctor, brochures, notes, receipts, etc.) You may attach the certification from your treating provider if you are seeing an expedited review. Send to:

Blue Cross Blue Shield of Arizona
Medical Appeals and Grievances Department
P.O. Box 13466, Mail stop A116
Phoenix, AZ 85002-3466
Phone: (602) 544-4938 or (866) 595-5998
Fax: (602) 544-5601

Signature of member or authorized representative _____ Date _____

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Provider Certification Form for Expedited Appeal

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Is the appeal for a service that the patient has not yet received? ☐ **Yes** ☐ **No**
If "Yes", continue with this form.
If "No", the patient must pursue the standard appeal process and cannot use the expedited appeals process.

Provider Information					
Treating Physician/Provider					
Phone #		Fax #			
Address					
City		State		Zip Code	

Patient Information					
Member Name		Member ID #			
Phone #		Fax #			
Address					
City		State		Zip Code	

What service denial is the patient appealing? _____

_____

_____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient:

_____

_____

_____

Fax this form with any supporting documentation and medical records to:
BCBSAZ at (602) 544-5601

I certify, as the patient's treating provider, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health or ability to regain maximum function, cause a significant negative change in their medical condition, or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature: _____ Date: _____
If you have questions about the appeals process or need help to prepare your appeal, please call BCBSAZ at (602) 864-4400 or (800) 232-2345

Non-Discrimination Statement

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877)475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
.]تماس حاصل نمایید

Assyrian:
ܐܢ ܐܝܬ ܠܟ ܐܘ ܠܐܢܫܐ ܕܐܢܬ ܥܒܕ ܠܗ ܥܕܪܐ، ܕܫܐܠ ܥܠ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܣܒ ܥܕܪܐ ܘܝܕܥܢܐ ܒܠܫܢܟ ܒܠܐ ܡܨܪܦܐ. ܟܕ ܬܡܠܠ ܥܡ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܣܪ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิ์ขอรับความช่วยเหลือและข้อมูลในภาษา ของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799