



Blue Cross Blue Shield of Michigan  
 Blue Care Network of Michigan  
 BCN Service Company  
 BlueCaid of Michigan

# HEALTH CARE PRIVACY COMPLAINT FORM

You have the right to file a complaint with us about our privacy policies, procedures and practices, as well as our compliance with our Notice of Privacy Practices or state and federal privacy rules and laws. You do not waive your state and federal privacy rights by filing your complaint. Filing a complaint will not influence your treatment, payment, or enrollment or eligibility for benefits. We will not retaliate against you for filing a complaint.

## Section A: Individual filing complaint

LAST NAME		FIRST		INITIAL	
DATE OF BIRTH (MM/DD/YY)			DATE OF INCIDENT		
ADDRESS			CITY		STATE
EVENING PHONE NUMBER		DAYTIME PHONE NUMBER		CONTACT HOURS (Please specify when you prefer to be called.)	

## Insured's Information (Person whose name appears on the ID card)

LAST NAME		FIRST		INITIAL	
Please Check One <input type="checkbox"/> BCBSM <input type="checkbox"/> BCN <input type="checkbox"/> BCMI			CONTRACT NUMBER (From your ID card or Explanation of Benefits statement.)		

## Section B: Complaint

Please give a simple, concise explanation of the complaint:

## Section C: Signature

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

\_\_\_\_\_ Signature \_\_\_\_\_ Date

*If the complaint is lodged by a personal representative on behalf of the individual, complete the following and check the appropriate box.*

Print Name of Personal Representative: \_\_\_\_\_

\_\_\_\_\_ Signature of Personal Representative \_\_\_\_\_ Date

Parent  Legal Guardian  Power of Attorney  Executor  Other \_\_\_\_\_

## Please return this form to:

Blue Cross Blue Shield of Michigan  
 Corporate & Financial Investigations, B759  
 27000 W. 11 Mile Road  
 Southfield, MI 48034

Processor's Information (for internal use only):	
NAME (Please Print)	PHONE NUMBER
_____ Signature _____	_____ Date _____