Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Anthem BlueCross BlueShield

Physician/Provider Grievance Form

Please fax the completed form to **1-855-535-7445**.

☐ Hoosier Healthwise ☐ Healthy Indiana Plan ☐ Hoosier Care Connect

Provider information

Date: ______________ Primary medical provider site number: ____________________________

Provider name: ______________________________ License number: ______________________

TIN: ____ NPI number: _________________________

Are you part of our provider network? ☐ Yes ☐ No

Address: ___________________________________ State: ____________ ZIP code: _________

Phone number: ______________________________ Fax number: _________________________

Information about the grievance
This information is part of the permanent record. Write clearly and legibly. Use additional pages if necessary.

☐ Policy issue ☐ Service issue ☐ Medical group issue ☐ Quality issue ☐ Other

Member name: ______________________________ Member ID number: ___________________

Date of incident: ____________________________

Describe what happened: ____

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Signature of provider: _____________________________________ Date: ___________________

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