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GRIEVANCE/APPEAL COMPLAINT REQUEST FORM

MEMBER LAST NAME: ________________________FIRST NAME: _______________

MEMBER ADDRESS: ______________________________________

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DATE OF BIRTH: ____________ MEMBERSHIP ID NUMBER: _______________________

NAME OF PERSON FILING APPEAL/GRIEVANCE: _____________________________________

_____ MEMBER ________PATIENT AUTHORIZED REPRESENTATIVE

IF PERSON FILING APPEAL/GRIEVANCE IS OTHER THAN PATIENT, PATIENT MUST INDICATE AUTHORIZATION BY SIGNING AND DATING BELOW:

SIGNATURE: ___________________________________ DATE: ________________

PRINT NAME: __________________________________

DAYTIME PHONE NUMBER: __________________ CELL PHONE NUMBER: ____________

PREFERRED CALL BACK TIME: ____

IS YOUR COMPLAINT OR CONCERN REGARDING: (PLEASE CHECK ALL THAT APPLY)

___ BENEFITS ____ SERVICES ____ DRUGS ___ OTHER

PLEASE GIVE AN EXPLANATION OF YOUR COMPLAINT AND/OR CONCERN:

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IF ADDITIONAL SPACE IS NEEDED PLEASE ATTACH ADDITIONAL PAGES
PLEASE KEEP A COPY OF ALL DOCUMENTS RELATED TO YOUR REQUEST

02/05/14 PAH