



MEMBER GRIEVANCE FORM

Date Submitted: _____ Health Plan: _____ LOB: _____

REQUESTOR INFORMATION		
<i>(is someone other than the member is filing this grievance, please provide the following):</i>		
Requestor:	Relationship to Member:	
Address:		
Phone:	Fax:	Email address:

PATIENT INFORMATION				
Patient Name:	DOB:			
Address:	City:	State:	Zip	
Phone:	Fax:	Member ID:		
Primary Insured's Name:				
Relationship to Patient:	SELF	SPOUSE	CHILD	OTHER:

PROVIDER INFORMATION		
Provider Name:	Specialty:	Facility Name:
Tax ID:	NPI:	Provider type:
Address:		

SERVICE INFORMATION			
Date of Service	Description	Claim Number	Reference Number

GRIEVANCE INFORMATION

Please describe your issue or concern below, providing detailed information about what happened, when it occurred, and who was involved. Be sure to include specific dates, times, names of people and providers, and locations. Additionally, please attach any relevant documents that may help us understand your grievance.

If you attach other pages, please check this box.

SIGNATURE

Sign here:

Signature of Member or Authorized Representative

Date:

Print Name of Member or Authorized Representative

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