CareSource PASSE

MEMBER GRIEVANCE AND APPEALS FORM

Member Name:

_____

Member Address:

_____

Member ID number:

_____

Best phone number to reach you:

_____

Please write a description of your grievance or appeal giving us as much detail as you can. Include the provider's information if your issue is with a provider. You may attach more pages, if needed.

_____

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_____

(Member Signature) **(Date Filed)**

CareSource PASSE will send you a letter with the result of your appeal no later than 30 days from the date we received this notice for a standard appeal, 72 hours for an expedited (fast) appeal and 30 days for a grievance.

OFFICE USE ONLY

Date Received: _____

Received By: _____

Grievance: _____ **Appeal:** _____

Member Services: 1-833-230-2005 (TDD/TTY: 711)