Member Grievance/Appeal Form

Member Information	
Member Name:	
Member ID Number:	**Member Phone Number:**
Member Address:	

If the grievance/appeal concerns a provider(s), please supply the following information, if known.

Name of Provider(s): _____

Address: _____

Telephone: _____

Please write a description of the grievance/appeal with as much detail as possible. Attach extra pages, if needed.

_____ _____

Member Signature Date Filed

OFFICE USE ONLY	Action taken to resolve grievance/appeal:
Date Received:	
Received By:	
Grievance/Appeal:	
Hearing Date:	_____ _____
	Plan Rep Signature Resolution Date