

Member Grievance/Appeal Form

Member Name _____	Member ID# _____
Member Address _____ _____ _____	Member Telephone _____

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 Date Received: _____ Received By: _____ Grievance/Appeal: _____ Hearing Date: _____	Action taken to resolve grievance/appeal: _____ (Signature Plan Rep) _____ (Resolution Date)
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