# *Member Grievance/Appeal Form* Indiana

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 Level 1 2
Hearing Date: ______________

Action taken to resolve grievance/appeal:

______________________________ (Signature Plan Rep)

______________ (Resolution Date)

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