CareSource Dual Advantage™ (HMO D-SNP) Grievance Form

If you have questions or need assistance with this form, please call Member Services at **1-833-230-2020**, (TTY **1-800-750-0750** or **711**). We are open 8 a.m. – 8 p.m. Monday through Friday, and from Oct. 1 – Mar. 31 we are open the same hours seven days a week.

Please type or print. You may also report your grievance over the phone. You need to contact us within 60 calendar days from the day when you had the problem.

Member Name:	Telephone Number:
Identification Number:	Provider Name:
Date of Birth:	Date(s) of Service:
Address:	
City, State, and Zip:	
Please state the nature of the grievance. Please give dates, times, persons, places, etc. that are involved. (Attach additional sheets, if necessary.)	
I authorize CareSource Dual Advantage (HMO D-SNP) to obtain any medical records needed to review my grievance. This approval begins on the date below and stays in effect as long as my request is being reviewed.	
Signature of Member or Authorized Representative*	
Today's Date:	
*Please attach documentation showing your authority to act on behalf of another. This may include a Power of Attorney or Appointment of Representative Form (Form CMS − 1696).	

Submit completed form to:

CareSource Dual Advantage (HMO D-SNP)
Attn: Member Appeals
P.O. Box 1432
Dayton, OH 45401-1432
Fax: 1-844-417-6153