



**NON-MEDICARE MEMBER FORMAL GRIEVANCE FORM**

Please use this form or a separate letter for information needed for the review of your grievance. Be as complete and detailed as possible. If the grievance is about a physician(s), be sure to list the name(s) of the doctor(s). If medication is the issue, list all the names of the medications. If the grievance is about a balance billing, please attach the billing statement from the provider.

Member Name: \_\_\_\_\_ Member Phone: \_\_\_\_\_

Member ID#: \_\_\_\_\_

Relationship to Member:  Self  Appointed Representative  Power of Attorney  Parent/Guardian

Type of Coverage:  Medicaid

Type of Grievance

- |                                       |  |
|---------------------------------------|--|
| _____ Physician Related               | _____ Enrollment/Disenrollment Related |
| _____ Hospital Related                | _____ Provider- Poor Customer Service  |
| _____ Delay in Getting Physician Care | _____ Telephone Problems               |
| _____ Delay in Getting Hospital Care  | _____ Transfer of Centers              |
| _____ Plan-Poor Customer Service      | _____ Other: _____                     |

Date of occurrence that caused grievance: \_\_\_\_\_  
(month, day, year)

Nature of Complaint:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I would like my grievance to be handled as:  Expedited/Urgent: 72 hours  Standard: 45 calendar days

If you feel should be handled as Expedited, explain why:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you like your grievance resolved?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What date(s) was the service provided? \_\_\_\_\_

Name of physician or hospital who provided the service: \_\_\_\_\_

Have you discussed this grievance with any company staff/personnel?  Yes  No

If yes, with whom?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What did they say?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If your grievance involves balance billing, have you paid the bill you are referencing?  Yes  No

Where did you receive the service? \_\_\_\_\_

When? \_\_\_\_\_ By whom? \_\_\_\_\_

Other comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY request a review of the Grievance described in this document and understand that in order for the Grievance to be reviewed, Harmony Health Plan, (the Health Plan), may need medical records and other records or other information related to my grievance. I authorize persons or entities that have any medical or other records, or knowledge of me or my dependants, to release such information to Harmony Health Plan (the Health Plan). Those persons or entities may include any: 1) licensed physician; 2) medical practitioner; 3) hospital, 4) clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7) other organization, institution, or person. I specifically authorize the release of the following records or information if need for the review of my Grievance: any and all medical records and information about, associated with, or with reference to: 1) a positive test result for HIV infection; 2) ARC; 3) AIDS; 4) alcohol or drug dependency; and 5) mental and nervous disorders.

I also understand that if the Grievance described in this form is not resolved to my satisfaction, I may request a Second-Level review to the Corporate Appeals and Grievance Committee.

\_\_\_\_\_  
Member Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member's or Representative's Signature

Please fax this form to (866) 388-1769, or mail to:

Harmony Health Plans, Inc.  
Attn: Grievance Department  
P.O. Box 31384  
Tampa, FL 33631-3384

WCPC-IMC-060