



GRIEVANCE/APPEAL REQUEST FORM

PLEASE PRINT OR TYPE

Last Name: _____ First Name: _____ Middle Initial: _____

Home Address: _____

Home Telephone: _____ DOB: _____

Member ID #: _____ Medicare ID #: _____

Date(s) of Service/Occurrence: _____

IMPORTANT: Below please describe the nature of your grievance/appeal and any facts you feel should be considered in the review of your grievance/appeal: (Use additional sheet(s) if necessary. If your grievance/appeal involves unpaid bills, please attach a copy of the bill(s) or a completed claim form). Complete, sign, and mail this request back to the address listed on this form. You can also fax it to the number listed on this form.

REQUEST FOR REVIEW

I HEREBY request a review of the grievance/appeal described above and understand that the receipt of this Grievance/Appeal Form by CarePlus Health Plans, Inc. (CPHP) constitutes a request for review. I understand that in order for CPHP to review my grievance/appeal, CPHP may need medical or other records or information relevant to my grievance/appeal. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me to release such information to CPHP in order for CPHP to complete its review of my grievance/appeal. This information will not be released to any other organization or individual except as permitted under Federal and State Law, pursuant to court orders or subpoenas. CPHP has established appropriate safeguards to ensure the privacy and confidentiality of all medical information and to prevent unauthorized access to it.

Member's Signature and/or Authorized Representative: _____	Date: _____
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I understand that CarePlus Health Plans, Inc. will contact me within five (5) working days from the date of receipt to acknowledge this grievance/appeal. Your benefits will continue during the course of this grievance/appeal as long as you remain enrolled in CarePlus Health Plans, Inc.

Please send and/or fax this signed form to:

CarePlus Health Plans, Inc.
11430 NW 20th Street, Suite 300
Doral, Florida 33172
Attn: Grievance/Appeals Department
Fax: 1-800-956-4288 or 305-423-3369

Medicare approved HMO plan



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If you need assistance in filling this form, please call our Member Services Department at 1-800-794-5907. If you have a speech or hearing impairment and use a TTY device, please call 1-877-245-7930. We are open 7 days a week, from 8:00 a.m. to 8:00 p.m. However, from (March 2nd) until the following Annual Election Period (AEP), you may leave a voice mail message after hours, Saturdays, Sundays, and holidays and we will return your call the next business day.

For CarePlus Health Plans, Inc. Use Only

Received by: _____

Date/Time: _____

By Mail

By Telephone

In Person

Other
