delaware first health

Member Information

Full Name: _____

Member ID #: _____

Date of Birth: _____

Authorized Representative Information

Name of Person Filing Grievance: _____

Relationship to Member: _____

Phone Number: _____

Email Address (optional): _____

Grievance Information

Date(s) of Service / Incident: _____

Summary of Grievance:

_____

_____

_____

Consent Statement

I, [Member Name], authorize [Representative Name] to file a grievance on my behalf with Delaware First Health. I understand that this may involve the disclosure of my protected health information (PHI) to the representative and to the health plan for the purpose of resolving the grievance.

This authorization is valid for the duration of the grievance process unless revoked in writing.

Member Signature: _____

Date: _____

If signed by an authorized representative:

I certify that I am legally authorized to act on behalf of the member.

Representative Signature: _____

Date: _____

Submission Instructions:

Submit this form via:

- Fax: 833-525-0054
- Member Portal

- Mail:

Delaware First Health
ATTN: Appeals and Grievances
PO Box 10353
Van Nuys, CA 91410-03534