

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 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

_____ Co-Pay Issues

Other: _____

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

Nature of Complaint:

What date(s) was the service provided? _____

Have you discussed this grievance with any Delaware First Health 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, Delaware First Health, (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 dependents, to release such information to Delaware First Health (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 also understand that if the Grievance described in this form is not resolved to my satisfaction.

Member Name (please print) Date

Member's or Representative's Signature

Please fax this form to 1-833-525-0054, or mail to:

Delaware First Health
Attn: Grievance Department
P.O. Box 10353
Van Nuys, CA 90410