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
_____Hospital Related
_____Delay in Getting Physician Care
_____Delay in Getting Hospital Care
_____Plan–Poor Customer Service
_____Enrollment/Disenrollment Related
_____Provider- Poor Customer Service
_____Telephone Problems
_____Transfer of Centers
_____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 (866) 388-1769, or mail to:

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