



**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:  'Ohana Health Plan - Medicaid

Type of Grievance

- |  |   |
|--|---|
| <input type="checkbox"/> Physician Related               | <input type="checkbox"/> Enrollment/Disenrollment Related |
| <input type="checkbox"/> Hospital Related                | <input type="checkbox"/> Provider- Poor Customer Service  |
| <input type="checkbox"/> Delay in Getting Physician Care | <input type="checkbox"/> Telephone Problems               |
| <input type="checkbox"/> Delay in Getting Hospital Care  | <input type="checkbox"/> Transfer of Centers              |
| <input type="checkbox"/> Plan-Poor Customer Service      | <input type="checkbox"/> 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: 30 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, 'Ohana Health Plan (the 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 'Ohana. 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 State Grievance Review from the Med-QUEST Division (MQD) at the address below.

Med-QUEST Division  
Health Coverage Management Branch  
P.O. Box 700190  
Kapolei, HI 96709-0190

The MQD Health Plan will review the grievance. MQD will contact you with a determination within 30 days of the date your request is received.

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

\_\_\_\_\_  
Date

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

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

'Ohana Health Plan  
Attn: Grievance Department  
P.O. Box 31384  
Tampa, FL 33631-3384