Member Grievance and Appeals Form

Member Name ______________________

Member ID# ______________________

Member Address ______________________

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Best phone number to reach you at if you have questions or need additional information related to your issue: ______________________

Please write a description of the grievance or appeal giving us as much detail as possible including the provider's information if your issue concerns a provider. You may attach additional pages, if needed.

______________________ Member Signature

______________________ Date Filed

OFFICE USE ONLY

Date Received: ______________

Received By: ______________

Grievance: ______________

Appeal: ______________

Hearing: ______________

CareSource will send you a letter with the outcome of your appeal or the resolution of your grievance no later than 30 calendar days from the date we received this notice for a standard appeal, 72 hours for an expedited appeal and 90 calendar days for a grievance.

GA-MMED-0023; DCH Approved 05/24/2017