Member Grievance/Appeal Form *Ohio*

Member Name _____ Member Address _____ _____ _____	Member ID# _____ Member Telephone _____

If the grievance/appeal concerns a provider(s), please supply the following information, if known.

Name of Provider(s)_____

Address _____

Telephone _____

Please write a description of the grievance/appeal with as much detail as possible. Attach extra pages, if needed.

_____ _____
(Member Signature) (Date Filed)

OFFICE USE ONLY Date Received: _____ Received By: _____ Grievance Level 1 2 Hearing Date: _____	Action taken to resolve grievance/appeal: _____ _____ (Signature Plan Rep) (Resolution Date)

Excerpted from approved H8452_OHMMC461