CHA
Health Plan

GRIEVANCE AND APPEAL FORM

Member ID #: _____ Date of Birth: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Home Address: _____
Home Telephone: _____

IMPORTANT: Below please describe the reason of your grievance/appeal; and any facts you feel should be considered in the review of your grievance/appeal: (Use additional sheet(s) if necessary. If your grievance/appeal involves unpaid bills, please attach a copy of the bill(s) or a completed claim form). Complete, sign, and mail this request back to the address listed on this form.

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Member's Signature and/or Authorized Representative: _____	Date: _____

Please send and/or fax this form to:
Clear Health Alliance
Attn: Grievance & Appeals Department
9250 W. Flagler Street, Suite 600
Miami, FL 33174-3460
Fax: 305-408-5880

If you have any questions, please call our Member Services Department at 1-877-577-9043 or to file a medically urgent appeal. Language interpreter services are also available in your language preference by contacting Member Services. TTY users should call 711, Florida Relay for assistance in reaching our Member Services Department. Our office hours are 8:00 a.m. to 7:00 p.m., Monday to Friday.