Instructions for Completing Grievance Form

This Form is not intended to replace an appeal of a specific service delay, denial, or enrollee cost-share amount.

The blank spaces in the form should be replaced (or filled in) to reflect the circumstances of the enrollee’s case. Please add additional pages as necessary to describe your case fully yet concisely.

Please make sure to search the document for all spaces and replace (or fill in) that information with the enrollee’s before mailing the Grievance Form.

Do not include this instruction sheet with your grievance.

Remember:

1. The enrollee should sign the form on the last page where indicated. If the enrollee cannot sign for him/herself, the Grievance should be signed by the enrollee’s authorized representative or, if none exists, the next of kin. (Indicate the individual’s relationship to the enrollee and include documentation for the representative if it exists.)

2. Keep a copy of the completed Grievance Form.

3. Mail the completed Grievance Form to the enrollee’s Medicare Advantage Plan’s grievance department. This address should be available either on the Plan’s website or in the paperwork the enrollee received upon enrollment.

4. A Grievance must be filed with the Medicare Advantage plan no later than 60 days after the incident that caused the Grievance.

5. You may also want to send a copy of the grievance to your regional Medicare office and to your Congressional representative and senators. If so, note on the bottom of the Grievance Form that you have copied them in the “cc” spaces provided.

6. Please send us a copy of your completed Grievance, or any questions, comments, or concerns, to the following address or email:
   Center for Medicare Advocacy Attn: Attorney Justin Lalor
   PO Box 350
   Willimantic, CT 06226
   or via email to Grievance@MedicareAdvocacy.org

__________________________

End of Instruction Page
Date: ____________________________

Medicare Advantage Plan Name:
__________________________________________ (the “Plan”)

Address for the Plan’s Grievance Department:
__________________________________________
__________________________________________

Re: Grievance - Filed Pursuant to 42 C.F.R. § 422.564
Enrollee:
[Enrollee’s Name] (the “Enrollee”)

Member Number (MBI):
__________________________________________

Provider Name:
[Name of Health Care Provider] (the “Provider”)

Incident Date(s):
__________________________________________

This Grievance is filed with the Medicare Advantage Plan (the Plan) in accordance with the provisions of 42 C.F.R. § 422.564, Section 30 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, Appeals Guidance published by the Centers for Medicare & Medicaid Services (“CMS”), and the written grievance procedures published and disseminated by the Plan in accordance with law.

Specifically, the Enrollee is dissatisfied with the Plan due to: (check and fill in all that apply)

☐ An enrollee’s involuntary disenrollment initiated by the plan;
☐ A change in premiums or cost sharing arrangements from one contract year to the next;
☐ Lack of quality of the care received;
☐ Difficulty contacting the plan;
☐ Interpersonal aspects of care;
☐ The appeals process;
☐ The plan’s decision not to expedite a coverage or appeal request;
☐ General dissatisfaction about a co-payment amount or other cost-sharing;
☐ General issue about a drug not being on the formulary or listed as an excluded drug;
☐ Calculation of True Out-of-Pocket (TrOOP) costs for prescription drug coverage;
☐ Other: ________________________________;
☐ Other: ________________________________.
Background Facts

The following is a description of the health care services, items, and/or drugs that the Enrollee has been receiving. For this section, I have detailed the background of the care for the Enrollee. I have also included evidence regarding physicians’ and/or therapists’ medical opinions about the necessity of the health care at issue.
Summary of the Plan’s Behavior Leading to the Grievance

For this section, I have detailed the dissatisfactory behavior of the Plan regarding the Enrollee’s health care at issue.
**Grievance:**

I am dissatisfied with the Plan’s behavior as outlined above and request that the Plan complete the following in accordance with law:

1) Complete a full investigation into this case;
2) Review and accept this grievance, any additional documents that I may have enclosed with this grievance, and any additional relevant evidence concerning this case;
3) Take prompt, appropriate action to remediate this dissatisfactory outcome; and
4) Contact me about this grievance and any remedial action, including but not limited to providing a written response within thirty (30) days to this grievance that addresses all issues raised.

If you require any additional information, please contact me directly at my phone number and/or address below.

Sincerely,

________________________________________
[Enrollee’s Signature]

________________________________________
[Enrollee’s Printed Name]

[Address and Phone Number]

cc: