GRIEVANCE/APPEAL & DISPUTE RESOLUTION FORM

COMPLAINT NUMBER:

INSTRUCTIONS:
Fill out this form as completely as possible, including as much detail about your concern and how you feel it could be resolved.

If you wish, Customer Services can assist you in completing the form. Customer Services is located at 1200 N. West Avenue, Jackson, MI 49202 or call 517-780-3332 or 1-866-630-3690 and in Hillsdale by appointment.

APPEAL TYPE: ☐ **EXPEDITED**

- ☐ FAMILY SUPPORT SUBSIDY DENIAL
- ☐ SECOND OPINION OF INITIAL ACCESS DENIAL
- ☐ SECOND OPINION OF HOSPITALIZATION DENIAL
- ☐ NEGATIVE SERVICE DECISION
- ☐ CONTRACT/CREDENTIALING DISPUTE

GRIEVANCE TYPE:

- ☐ QUALITY OF TREATMENT
- ☐ QUALITY OF SERVICE
- ☐ AUTHORIZATION/HOSPITAL RECONSIDERATION
- ☐ CLAIMS DISPUTE
- ☐ REQUESTING CHANGE IN PSYCHIATRIST

Did complainant try to resolve before filing grievance/appeal (i.e. speak to doctor, therapist, Team Supervisor, etc.)
☐ Yes ☐No ☐N/A

COMPLAINANT'S NAME:	**COMPLAINANT'S PHONE NUMBER:**
COMPLAINANT'S ADDRESS:	**NAME OF CONSUMER INVOLVED (if applicable):**

EXPLAIN/DESCRIBE THE GRIEVANCE/APPEAL/REQUEST (You may attach additional pages if necessary):

HOW DO YOU FEEL THIS COULD BE RESOLVED?

SIGNATURE OF PERSON COMPLETING FORM

DATE

GRIEVANCE/APPEAL & DISPUTE RESOLUTION FORM

ADDITIONAL INFORMATION: