Member Grievance/Appeal Request Form

Mail this form to:
Molina Healthcare of Florida
Appeals & Grievance Unit
PO Box 36030
Louisville, KY 40233-6030
Toll free: (866) 472-4585
Fax Number: (877) 508-5748

Please Print

Member's name: _____ Today's date: _____

Name of person requesting grievance, if other than the Member; please complete Appointment of Representative form attached:
_____

Relationship to the Member: _____

Member's ID #: _____ Daytime telephone _____

Specific issue(s): _____

_____

_____

_____

(Attach another sheet of paper to this form if more space is needed)

Member's Signature _____ Date: _____

If you would like assistance with your request, we can help. You can call or write to us at:

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Instructions for filing a grievance/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach to this form, copies of any records you wish to submit. (Do Not Send Originals).
3. You may present your information in person. To do this, call us at 1-866-472-4585.
4. We can help you write your request and we can help you in the language you speak. If you need services for the hard of hearing, you may call our TTY phone number at 711.
5. If you are over the age of 18 and have someone else acting on your behalf, a signed Appointment of Representative (AOR) form is needed. Please use the AOR Form that is enclosed.
6. You, and/or someone you have chosen to act on your behalf, can review your appeal file before or during the appeal process. Your appeal file includes all of your medical records and any other documents related to your case.
7. Return this completed form to

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   Appeals & Grievance Unit
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8. We will send a written verification of receipt of your request.

Thank you for using the Molina Healthcare Member Grievance Process.

Appointment of Representative (AOR) Form

Member Name _____ **Molina Member ID Number** _____

APPOINTMENT OF REPRESENTATIVE

I agree to name _____(Name and address) to be my representative with a grievance or an appeal for _____(specific issue).

I approve this person to make or give any request or notice; present or evidence; to obtain information, including, without limitation, the release of past, present or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in relation with my pending grievance/appeal.

SIGNATURE (member) _____ **ADDRESS** _____

TELEPHONE NUMBER (AREA CODE) _____ **DATE** _____

ACCEPTANCE OF APPOINTMENT

I, _____, hereby agree to the above appointment. I certify that I have not been suspected or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.

I am a/an _____
(Attorney, union representative, relative, etc.)

SIGNATURE (Representative) _____ **ADDRESS** _____

TELEPHONE NUMBER (with Area Code) _____ **DATE** _____

Please note: If you have a disability and need more help, we can help you. If you need someone that speaks your language, we can also help. You may call our Member Services Department at 1-866-472-4585 for more help from 8:00 am to 7:00 pm. If you are blind or have trouble hearing or communicating, please call 711 for TTY/TTD services. We can help you get the information you need in large print, audio (sound), and braille. We provide you with these services for free.

Tenga en cuenta lo siguiente: si tiene una discapacidad y necesita más ayuda, podemos ayudarlo. También podemos ayudarlo si necesita a alguien que hable en su idioma. Para obtener más ayuda, puede llamar a nuestro Departamento de Servicios para Miembros al 1-866-472- 4585, de 8:00 a. m. a 7:00 p. m. Si es ciego o tiene problemas de audición o comunicación, llame al 711 para acceder a servicios de TTY/TDD. Podemos ayudarlo a obtener la información que necesita en letra de molde grande, audio (sonido) y en sistema Braille. Estos servicios son gratuitos.

Remake: Si ou gen yon andikap epi ou bezwen plis èd, nou kapab ede w. Si ou bezwen yon moun ki pale lang ou an, nou kapab ede w tou. Ou gendwa rele Depatman Sèvis Manm nou an nan 1-866-472-4585 pou jwenn plis èd soti 8è:00 a.m. rive 7è:00 p.m. Si ou avèg oswa ou gen difikilte pou tande oswa pou kominike, tanpri rele 711 pou sèvis TTY/TTD yo. Nou kapab ede w jwenn enfòmasyon oubezwen an gwo karaktè, odyo (son) ak an Bray. N ap ba w sèvis sa yo pou gratis.

Xin lưu ý: Nếu quý vị là người khuyết tật và cần thêm trợ giúp, chúng tôi có thể giúp quý vị. Nếu quý vị cần người có thể nói ngôn ngữ của quý vị, chúng tôi cũng có thể giúp. Quý vị có thể gọi cho Bộ phận Dịch vụ thành viên của chúng tôi theo số 1-866-472-4585 để được trợ giúp thêm từ 8:00 am đến 7:00 pm. Nếu quý vị bị mù hoặc có vấn đề về thính giác hoặc giao tiếp, vui lòng gọi 711 cho dịch vụ TTY/TTD. Chúng tôi có thể giúp quý vị nhận thông tin quý vị cần bằng bảng chữ in lớn, âm thanh và chữ nổi Braille. Chúng tôi cung cấp miễn phí các dịch vụ này cho quý vị.