

**Grievance Form**

A grievance is a type of complaint you make expressing dissatisfaction with the way Clover Health or one of our network providers or pharmacies provided health care services, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment determinations. You must file a grievance within 60 days of the event or incident.

You may mail or fax this form to us at:

Clover Health

Attention: Appeals and Grievances

Harborside Financial Center

Plaza Ten, Suite 803

Jersey City, NJ 07311

Fax: (732) 412-9706

You may also file a grievance by calling us at 1-888-657-1207. TTY users should call 711. We are open 8 a.m. - 8 p.m. EST, 7 days a week. From February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

**Who May File a Grievance**: If you want another individual (such as a family member or friend) to file a grievance for you, that individual must be your representative (see required documentation below). Contact us to learn how to name a representative.

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| **Member Information**Member Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member Plan ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Complete the following section ONLY if the person making this request is not the member:** Requestor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Requestor’s Relationship to Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Representation documentation for grievances made by someone other than member:** Attach documentation showing the authority to represent the member (a completed Appointment of Representative (AOR) Form or other legal documentation that demonstrates representation per State law (e.g., a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute). For more information on appointing a representative and how to obtain an AOR Form please contact Customer Service at 1-888-657-1207. TTY users should call 711. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. |
| **Type of Grievance**Please choose one: □ Medical benefits □ Pharmacy benefits □ Other**Description of Grievance** (Attach additional pages, if necessary.) Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Clover Health is a Preferred Provider Organization (PPO) with a Medicare contract. Enrollment in Clover Health depends on Contract Renewal.*