**Grievance Request Form**

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| Member Name: | | ID #: |
| **Representation documentation for grievance requests made by someone other than**  **enrollee:**  Attach documentation showing the authority to represent the enrollee (a completed Appointment of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact the plan. You can also contact 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY/TTD users can call 1-877-486-2048. | | |
| Requestors Name (if other than member): | | |
| Relationship to member: | | |
| *If representing the member, the below 3 lines of information should be your information.* | | |
| Address: | | |
| City: | State: | Zip: |
| Telephone #: | | |
| Date of Incident: | | |
| Please indicate the reason for the grievance: | | |
| Is there additional information we should consider when reviewing this grievance? | | |
| Signature: | | Date: |

Please mail or fax completed form to:

ATRIO Health Plans

Attn: Appeals and Grievances

PO Box 5600

Scranton, PA 18505

Fax: 1-866-339-8751

For assistance with this form or questions regarding your grievance, please contact our Customer Service Department at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.