P.O. Box 30196
Salt Lake City, UT 84130-0196
Phone **844-208-9012** (toll-free)
Fax **801-442-0762**
selecthealth.org/medicare

selecthealth ADVANTAGE

GRIEVANCE FORM

USE THIS FORM FOR COMPLAINTS, OTHER THAN A DENIED CLAIM

If you have questions, call our Complaints and Appeals department at the number above weekdays, from 8:00 a.m. to 6:00 p.m. You may also contact Member Services toll-free at **855-442-9900** during the following dates and times:
October 1 to March 31 – weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
April 1 to September 30 – weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday. Outside of these hours, please leave a message and your call will be returned within one business day. TTY users, please call 711.

Member Name _____ Member ID# _____

Street Address _____ City _____ State _____

ZIP _____ Ph# (_____)_____ Email Address_____

Provider _____ Name, if you are not the member _____

Date of Birth _____/_____/_____ Date(s) of Event _____/_____/_____

❑ Check this box if your grievance/complaint is about the care you received.

A. THE REASON FOR YOUR COMPLAINT

B. WHAT WRITTEN AND/OR VERBAL COMMUNICATION HAVE YOU RECEIVED? FROM WHOM?

C. WHAT WOULD YOU LIKE US TO DO?

D. HOW WOULD YOU LIKE US TO CONTACT YOU ABOUT THIS GRIEVANCE?

❑ Email _____ ❑ Mail_____ ❑ Fax _____

SIGNATURE

Attach copies of any related documents (such as referrals, claims, bills, or letters from doctors). **Fax these with this completed form to 801-442-0762. You may also mail them to the address above.**

I AUTHORIZE SELECTHEALTH TO REVIEW MY COMPLAINT. I UNDERSTAND THAT THIS MAY REQUIRE A REVIEW OF MY MEDICAL RECORDS.

Signature _____ **Date** _____/_____/_____
Member or Representative

Free interpreting services provided upon request.
SelectHealth is an HMO, HMO-SNP plan sponsor with a Medicare contract. Enrollment in SelectHealth Advantage depends on contract renewal.

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