HIGHMARK. Delaware HEALTH OPTIONS

Member Grievance Form

Date: _____

Member Name: _ **Member ID #:** _____

Parent/Guardian: _____ **Relationship:** _____

Address: _____

Phone #: _____ **Completed by:** _____

The following questions will help us understand your grievance. If you need help, please call Highmark Health Options Member Services at 1-844-325-6251 / TTY 711 or 1-800-232-5460.

1. **Please explain the details of your grievance. Please include as much information as possible, including the issue, names of staff or doctors involved, type of service or item, and dates of service so that we can address your grievance appropriately.**

Please turn to 2nd page for a few more questions

2. What outcome do you want to happen as a result of your grievance?

Your Rights:

1. You have the right to submit evidence or allegations of fact or law, in person, or in writing.

2. You or your representative have the right to review any information related to your grievance, free of charge.

3. You have the right to have a Highmark Health Options staff member assist you in the grievance process.

4. If you are a member representative or a provider filing on behalf of a member, you must obtain the member's written consent.

These Rights have been explained by: Date:

Member or Guardian signature Date

Relationship to above