



GRIEVANCE/APPEAL FORM

**Mail To: 9250 W. Flagler St. Suite #600
Miami, FL 33174
Attn: Grievance and Appeals Department**

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Telephone: _____ **DOB:** MM/DD/YYYY **Member ID:** HealthSun ID#

Medicare ID: _____

Date(s) of service or occurrence: _____

Below, please describe the nature of your grievance/appeal and any facts you feel should be considered in the review of your grievance/appeal: (Use additional sheet(s) if necessary. If your grievance/appeal involves unpaid bills, please attach a copy of the unpaid bill(s) or a completed claim form).

REQUEST FOR REVIEW

I HEREBY request a review of the grievance/appeal described above and understand that the receipt of this Grievance/Appeal Form by HealthSun Health Plans (HSHP) constitutes a request for review. I understand that in order for HSHP to review my grievance/appeal, HSHP may need medical or other records or information relevant to my grievance/appeal. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me to release such information to HSHP in order for HSHP to complete its review of my grievance/appeal. This information will not be released to any other organization or individual except as permitted under Federal and State Law, pursuant to court orders or subpoenas. HSHP has established appropriate safeguards to ensure the privacy and confidentiality of all medical information and to prevent unauthorized access to it.

Member Signature

Date

Your benefits will continue during the course of this grievance/appeal as long as you remain enrolled in HealthSun Health Plans, Inc.

Internal Use Only

Received by: _____ Date/Time: _____
 By Mail By Telephone In Person Other: _____