GRIEVANCE/APPEAL FORM

HealthSun HEALTH PLANS

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:** _____ **Member ID:** _____
MM/DD/YYYY *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 bill(s) or a completed claim form).

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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**

I understand that HealthSun Health Plans will contact me within five (5) working days from the date of receipt to acknowledge this grievance/appeal. 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:_____

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).