

# APPEAL OR GRIEVANCE FORM



If you have a complaint or appeal related to your Clear Spring Health plan or any aspect of your care, we want to hear about it and see how we can help. You can use this form to tell us what happened and how you're feeling. Please provide complete information, so we can get your issue to the associate who can help you best.

This form, along with any supporting documents (such as receipts, medical records, or a letter from your doctor) may be sent to us by mail or fax:

**Address:**

Clear Spring Health  
Attention: Appeals & Grievances  
PO Box 3040  
Spring Hill, FL 34611

**Fax Number:**

1 (866) 235-5181

## 1. WHO IS THE MEMBER

Member Name (First and Last)

CSH Member ID Number

Member birthdate (MM/DD/YYYY)

Person acting on member's behalf (if someone other than the member)

Street Address

City

State

ZIP Code

Phone Number (with area code)

## 2. WHAT WAS THE ISSUE?

First, help us understand what this was about:

- A medical service (or medical equipment)
- An issue not related to a specific medical service or medication

**For a specific medical service, please provide the details:**

Service

Provider (Physician, Facility)

Have you already received the medical service?

- Yes
- No

Service date (MM/DD/YYYY)

Claim number (if you have one)

## 2. WHAT WAS THE ISSUE? (Continued)

**What should we know about this issue?** Please be as specific as possible about what happened and who was involved. Include any dates of service or contact with Clear Spring Health employees, healthcare providers or pharmacies. If you run out of room, feel free to write on the back or add an extra page.

**What additional information can you share?** Please attach copies of any supporting information or documents that we should review, such as receipts for services already paid for, medical records, or a letter from your provider.

### What documents have you attached?

- |  |  |
|--|--|
| <input type="checkbox"/> Receipt(s)      | <input type="checkbox"/> Letter from your provider |
| <input type="checkbox"/> Medical Bill(s) | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Other: _____              |

**Does your appeal need to be expedited?** Expedited appeals are only appropriate for services that haven't been rendered yet and if you and your provider believe that waiting for a standard decision could seriously harm your life, health or ability to regain maximum function. To process an expedited appeal, we'll need your provider to share a statement indicating why your request should be expedited.

- Please check this box if you need an expedited decision within 72 hours, and you have a supporting statement from your provider.**

## 3. DO YOU NEED TO APPOINT A REPRESENTATIVE?

**Skip this section if you are the member acting on behalf of yourself.**

If you are not the member and aren't sure if you're authorized to work with Clear Spring Health on the member's behalf, please complete this section with the member. (Note: If you are a provider or legal representative, you will need to complete a separate Appointment of Representative Form that can be found [here](#).)

Member's Medicare ID Number

Representative Name (first and last)

Relationship to Member

Street Address

City

State

ZIP Code

Phone Number (with area code)

#### 4. SIGN AND SUBMIT

Member Signature (or physician)	Date
Authorized Representative Signature (if you filled out section 3)	Date

**Thanks for taking the time to inform us of this issue. We'll be in touch with you if we have any questions, and we'll get back to you as soon as we complete our investigation of the issue.**