MEMBER GRIEVANCE FORM

Clear Spring Health

Instructions: This form is optional. You may also file a complaint by calling Clear Spring Health's Member Services Department. If you have questions about this form or would like to file a complaint verbally, please call us at 1-877-364-4566 (TTY: 711). We are open from October 1–March 31, seven days a week, 8:00 am – 8:00 pm and from April 1 – September 30, Monday through Friday, 8:00 am – 8:00 pm (you may leave a voicemail Saturday, Sunday and Federal Holidays). We want to help you resolve your complaint to your satisfaction as quickly as possible.

Complaint Filed By:

☐ Member/Self ☐ Provider* ☐ Authorized Representative*

***PLEASE NOTE**: If anyone other than the member has completed and signed this form, a completed Appointment of Representation Form (AOR), or Equivalent Written Notice must be provided to the Plan before this Grievance may be investigated.

We will notify you of our decision as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," or we decided we need more time to review your request for a medical care or appeal of denied medical care we will automatically give you a "fast complaint" and respond to your complaint within 24 hours. If you have an urgent problem that involves an immediate and serious risk to your health, you can request a "fast complaint" and we will respond within 72 hours.

MEMBER INFORMATION	
Member Last Name:	Member First Name:
Member Plan ID or MBI #	Phone #:

DESCRIPTION OF YOUR GRIEVANCE OR EXPRESSION OF DISSATISFACTION
Date of Occurrence/ Date of Service:

Member's Signature:	Date:

Your rights during the grievance process:

- You (or your representative) have the right to submit evidence or allegations of fact or law, in person or in writing.
- You (or your representative) have the right to review any information related to your grievance.
- You (or your representative) have the right to have a Clear Spring Health staff member help you through the Grievance process.

Return this completed form by mail, email or fax to:

Mail:
Clear Spring Health
Attn: Grievance & Appeal Department
10555 Group1001 Way
Zionsville, IN 46077

Email: A&G@clearspringhealthcare.com

Fax: 1.866.235-5181

Clear Spring Health has a contract with Medicare to offer PPO and HMO Plans. Enrollment in these plans is dependent on annual contract renewal with the federal government.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística llame al 1-877-364-4566 (TTY:711).