Clear Spring Health
Prescription Drug Plan (PDP)
Member Grievance Form

Medicare Advantage Prescription Drug (MAPD) members should use the "Medicare Advantage Prescription Drug Plan Grievance Form"

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 1-877-842-9790 (TTY: 1-800-899-2114). We are open 24 hours a day, 7 days a week. 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:** ______________________

Clear Spring Health
Prescription Drug Plan (PDP)
Member Grievance Form

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:

Clear Spring Health
Attn: Express Scripts
Grievance Resolution Team
P.O. Box 3610
Dublin, OH 43016-0307

Fax: 1-614-907-8547