AlohaCare

MEMBER GRIEVANCE FORM

Date Rec'd: _____ Taken By: _____

Member Name: _____ Member ID#: _____

Mailing Address: _____ Telephone#: _____

Name of Grievant: _____ Relationship to Member: _____

Note: If a representative is filing an oral grievance on behalf of an adult member, please obtain a verbal authorization from the member and fill out an Authorization To Disclose Protected Information form.

Type of Contact:

- ☐ Letter
- ☐ Telephone — Member Request Copy of Grievance? Yes ☐ No ☐
- ☐ In Person — Member Request Copy of Grievance? Yes ☐ No ☐

Grievance Regarding:

- ☐ Provider — Full Name: _____
- ☐ Health Plan

Date(s) of Service or Care: _____

Description of Grievance: _____

☐ Recapped written grievance with member verbally on: _____

For Grievance Coordinator Use Only: File#: _____

Sent copy of grievance to member on: _____/_____/_____ Sent acknowledgement letter on: _____/_____/_____

Sent to QI Dept on: _____/_____/_____ Revised 07/01/03 mr