HIGHMARK HEALTH OPTIONS

Member Grievance Form

As a Highmark Health Options member, you can submit a grievance. A grievance is a statement of unhappiness, like a complaint, and can be about any service that your received from Highmark Health Options or a health care provider. A grievance can be filed at any time.

How to submit this form: Use the enclosed reply envelope to return this form and any documents that will help us look into your complaint. If you do not have a reply envelope, mail to:
Highmark Health Options
Attn: Appeals and Grievances
P.O. Box 106004
Pittsburgh, PA 15230

What happens next: We will send you a letter to let you know we received your form. We will review the form and all supporting documents you have sent to us.

Need help?
Call Member Services at 1-844-325-6251 or read about the grievance process in your Member Handbook.

Use this form to file a grievance.

Please complete as much of the form as you can. Here is what you need to provide:

Member information: Find this on your member ID card.

Patient Information: Provide information about the person the request is for. If this person is the same as the member, leave this section blank.

Service/Claim Information: Tell us about the service, claim, or item related to your grievance. Find this information in letters from Highmark Health Options.

Reason for Grievance: Tell us about your grievance. Use additional paper if necessary. Include the names of any staff or doctors involved, type of service, and service dates.

Print First and Last Name: Print the name of the person listed in the Patient Information section if that person is 18 or older, or print the name of the parent or guardian.

Signature: The person listed in the Patient Information section should sign if that person is 18 or older. If that person is under age 18, the parent or guardian should sign.

Choose an authorized representative:
You can choose to have an authorized representative help you with your appeal. To appoint an authorized representative, complete the Member Appeal Representation Authorization Form.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

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Member Information

Today's Date	Member ID Number	Date of Birth
First Name	Last Name	Primary Phone Number
Street Address		
City, State, ZIP		

Patient Information If same as above, leave blank.

First Name	Last Name	Date of Birth

Service Information

Provider Name	Date(s) of Service(s)
Provider Address	Provider Phone

Explain the Details of Your Grievance If more space is needed, use additional paper.

What do you want to happen as a result of your grievance?

Understanding Your Rights

1. You have the right to submit evidence or allegations of fact or law, in person or in writing.
2. You or your authorized representative have the right to review any information related to your appeal, free of charge.
3. You have the right to have a Highmark Health Options staff member assist you in the appeal process.
4. If you are a member's authorized representative or a provider filing on behalf of a member, you must obtain the member's written consent.

Print First and Last Name	Signature