# Member Grievance/Appeal Request Form

**Mail this form to:**

**Molina Healthcare of Florida**
**Attn: Grievance & Appeal Department**
PO BOX 521838
Miami, Florida 33152-1838
Toll free: (866) 472-4585
Fax Number: (877) 508-5748

**Please Print**

Member's name: _____ Today's date: _____

Name of person requesting grievance, if other than the Member; please complete Appointment of Representative form attached:

_____

Relationship to the Member:

_____

Member's ID #: _____ Daytime telephone: _____

Specific issue(s):

_____

_____

_____

_____

(Attach another sheet of paper to this form if more space is needed) -

Member's Signature _____ Date: _____ -

If you would like assistance with your request, we can help. You can call or write to us at: -

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# Member Grievance/Appeal Request Form

Instructions for filing a grievance/appeal:

1. - Fill out this form completely. Describe the issue(s) in as much detail as possible.

2. - Attach to this form, copies of any records you wish to submit. (Do Not Send Originals).

3. - You may present your information in person. To do this, call us at 1-866-472-4585.

4. - We can help you write your request and we can help you in the language you speak. If you need services for the hard of hearing, you may call our TTY phone number at 1-800-955-8771.

5. - If you are over the age of 18 and have someone else acting on your behalf, a signed Appointment of Representative (AOR) form is needed. Please use the AOR Form that is enclosed.

6. - You, and/or someone you have chosen to act on your behalf, can review your appeal file before or during the appeal process. Your appeal file includes all of your medical records and any other documents related to your case.

7. - Return this completed form to

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**PO BOX 521838**
**Miami, Florida 33152-1838**
**Fax: 1-877-508-5748**

8. We will send a written verification of receipt of your request.

Thank you for using the Molina Healthcare Member Grievance Process.

# Appointment of Representative (AOR) Form

**Member Name** _____ **Molina Member ID Number** _____

## APPOINTMENT OF REPRESENTATIVE

I agree to name _____(Name and address) to be my representative with a grievance or an appeal for _____(specific issue).

I approve this person to make or give any request or notice; present or evidence; to obtain information, including, without limitation, the release of past, present or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in relation with my pending grievance/appeal.

**SIGNATURE (member)** _____ **ADDRESS** _____

**TELEPHONE NUMBER (AREA CODE)** _____ **DATE** _____

## ACCEPTANCE OF APPOINTMENT

I, _____, hereby agree to the above appointment. I certify that I have not been suspected or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.

I am a/an _____
**(Attorney, union representative, relative, etc.)**

**SIGNATURE (Representative)** _____ **ADDRESS** _____

**TELEPHONE NUMBER (with Area Code)** _____ **DATE** _____