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: _____

If you are not the member, give us your name. Please fill out and sign the "Appointment of Representative Form" attached. You don't have to use this form. If so, you can send us a written and signed letter by the member:

_____

Relationship to the Member: _____

Member's ID #: _____ Daytime telephone _____

Specific issue(s): _____

_____

_____

_____

(If you need more space, you can send us another paper.)

Member's Signature _____ Date: _____

If you would like help with your request, you can call or write to us at:
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How to file a grievance or appeal:

1. Fill out this form. Tell us the issue(s) as best as you can.
2. You may want to send us copies of your records. If so, please send it with along with this form or the written approval. (Do Not Send Originals).
3. You may give us your info in person. To do this, call us at 1-866-472-4585.
4. We can help you write your request. 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 18 and over; and have someone else acting on your behalf, an Appointment of Representative (AOR) Form is needed. We will check our files to see if you have already been approved. You can also send us a written and signed letter, letting the person act on your behalf in place of the. Molina Healthcare gives you an "Appointment of Representative Form" for your benefit. Please use the AOR that is attached or send us a written and signed letter.
6. We will still work the grievance or appeal but the info will not be sent to you until you are approved by the Member. If we do not receive any kind of approval, the decision will be sent only to the member.
7. You may want to see the case file. You can ask to see or get copies of the case file at any time. This is free. Your file can have all of your medical records. It can also have any other papers about to your case.
8. You may have let someone act on your behalf. If so, they can also go over your grievance or appeal file.
9. Fill out and send to:

Molina Healthcare of Florida
Attn: Grievance & Appeal Department
PO BOX 521838
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8. We will send you a letter. The letter will let you knowwe got 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 act on my behalf for a grievance/appeal for _____ (specific issue).

I approve this person to make or give any request or notice for me. This person can present or show any facts or evidence. This person can also get info on any past, present or future treatments, testing, evaluations, drugs, diagnosis, and results. This person can also talk about all my medical care or services. This person can also talk about my claims or bills I may have received. In addition this person can receive any notice about my pending grievance or appeal.

_____ _____

SIGNATURE (member) **ADDRESS**

_____ _____

TELEPHONE NUMBER (AREA CODE) **DATE**

ACCEPTANCE OF APPOINTMENT

I, _____, agree to the above. I confirm that I have not been suspected or banned from practice before the Social Security Administration. I am not a current or former officer or employee of the United States disqualified as acting as the members' representative; that I will not charge or get any fee(s) for the representation unless it has been approved in agreement with the laws and regulations.

I am a/an _____

(Attorney, union representative, relative, etc.)

_____ _____

SIGNATURE (Representative) **ADDRESS**

_____ _____

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