FAMILY HEALTH CHOICE

Appeal, Complaint or Grievance Form

If you have a complaint or appeal related to your Discount or Medical plan or any aspect of your care, we want to hear about it and see how we can help. You can use this form to tell us what has happened. Please provide complete information, so we can get your issue to the associate who can help you best.

This form, along with any supporting documents (such as receipts, medical records, or a letter from your doctor) may be sent to us by mail or call us at:

Address: Family Health Choice
Attn: Customer Service/Complaints
1806 N. Flamingo Road, Suite 220
Pembroke Pines, FL 33028

Phone Number: 954-928-9962

1	**Member Information**

Member name (first and last)	
Member ID number	Member birthdate (MM/DD/YY)
Street address	Phone number (with area code)
State / Zip Code	City

2	**What is the issue?**

First, help us understand what this was about:

☐ A medication
☐ A medical service
☐ An issue not related to a specific medical service or medication

For a specific medical service or medication, please provide the details:

Service or medication
Provider (Physician or Medical Facility Name)

Have you already received the medical service or medication? ☐ Yes ☐ No	If Yes, how much have you paid in services?
Service date (MM/DD/YY)	

2 | **What was the issue?** *(Continued)*

What should we know about this issue? Please be as specific as possible about what happened and who was involved. Include any dates of service or contact with a Family Health Choice employee, healthcare providers or pharmacies.

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What additional information can you share? Please attach copies of any supporting information or documents that we should review, such as receipts for medications or services already paid for, medical records, or a letter from your provider.

What documents have you attached?:

☐ Receipt(s)
☐ Medical Records
☐ Letter from your provider

☐ None
☐ Other _____

3 | **Sign and Submit**

_____

Member Signature

_____

Date

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