Grievance and Appeal Form

Requester Information		
Last Name:	**First Name:**	**Phone #:**
Address:		
City:	**State:**	**Zip:**

Patient Information		
Last Name:	**First Name:**	
ID:	**Date of Birth:**	
Phone #:	**Email:**	
Address:		
City:	**State:**	**Zip:**

Prescriber Information		
Last Name:	**First Name:**	
Address:		
City:	**State:**	**Zip:**
Phone #:	**Prescriber Fax #:**	**Date(s) of Service:**

Describe your complaint or appeal. Please provide as much detail as possible and attach all relevant information on additional pages if needed.

☐ **Expedited/Urgent Review Requested:** By checking this box I certify that an urgent review is needed for the appeal request to avoid seriously jeopardizing the patient's health or ability to regain maximum function.

I certify that the above information is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

Submit this form and supporting information via fax to 503-346-8351