Grievance Form

Subscriber Name: _____

Member ID Number: _____

Patient Name: _____

Please Check one: _____ Subscriber _____ Patient _____ Authorized Representative

Contact information of person filing grievance (if different from patient)

Address: _____

Phone: _____

Describe the concern in detail:

How have you tried to resolve the concern(s)?:

What can we do to resolve the concern(s)? (Use additional sheets if necessary)

Send completed form to: PO Box 4278 Clinton IA 52733-4278
For questions: 855-571-1378

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OhioHealthy