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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