Grievance Form

Use this form to submit a formal complaint or grievance about anything other than a benefit or claim denial. If your grievance is regarding a benefit or claim denial, please use our Medical Appeal Form or Pharmacy Appeal Form.

St Luke's™ + Health Plan

Subscriber Name:		**Patient Name** (Person that is the subject of the grievance):
Subscriber ID:		**Patient DOB:**
Street Address:		**Phone:**
City:		**Email** (optional):
State:	**Zip:**	**Expedited/Urgent?** No ☐ Yes ☐
Do you want us to contact you to follow up regarding this grievance? No ☐ Yes ☐		**Preferred method of contact regarding this grievance:** Phone ☐ Email ☐ Mail ☐

Why are you filing a grievance?

What is your desired outcome?

Consent

I give St. Luke's Health Plan permission to investigate my grievance, review medical records associated with the grievance and talk to my doctor about my grievance if necessary.

Signature: _____ **Date:** _____

Relationship to patient: _____

Send completed forms via fax, email, or mail:

Fax: 888-400-1654 **Email:** appeals@stlukeshealthplan.org
Mail: ATTN: Appeals Coordinator, St. Luke's Health Plan, PO Box 91010 Seattle, WA 98111
Questions? Call the Appeals Department at **833-353-0312.**