

# 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.

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

**Email:** [slplanappeals@slhealthplan.org](mailto:slplanappeals@slhealthplan.org)

**Mail:** ATTN: Appeals Coordinator, St. Luke's Health Plan, PO Box 1739, Boise, ID 83702-5809

**Questions?** Call Customer Service at **833-840-3600**.