Nascentia Health PLUS
TOMORROW'S HEALTHCARE TODAY

Member Appeal and Grievance/Complaint Form

You can use this form to file an appeal or grievance within 60 days of the initial determination or date of the event. Please attach copies of all documents you may have in relation to this request and include any additional information, which may support your complaint. This form and any documentation may be mailed or faxed to:

Address: Nascentia Health Plus
Grievance and Appeals Dept
1050 West Genesee Street
Syracuse, NY 13204

Fax Number: 1-315-870-7788

Member Information

Member Name (first and last)			Date of Birth (MM/DD/YY)
Street Address			Member ID Number
City	State	Zip Code	Phone Number (with area code)
What is your concern about? ☐ Medication ☐ Medical Service ☐ Other			Have you already received the medication or medical service? ☐ Yes ☐ No

Information About the Concern

Medication or Medical service			
Provider Name (Physician/Facility/Prescriber)			Provider Phone Number (with area code)
Provider Street Address			Date of Service (MM/DD/YY)
City	State	Zip Code	Claim or Authorization Number

Please inform us about this concern. Be as specific as possible about what happened and who was involved. You may attach copies of any supporting information or documents that we should review. If you want to be represented by another person for your appeal, complete an Appointment of Representative (AOR) form available by contacting Members Services at 1-888-4777-HOME (4663) or online at:
https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html

Member Name (first and last)

Indicate what you want to file:

- ☐ **Standard Grievance**-a complaint about quality, customer service or similar issue.
- ☐ **Expedited Grievance**- a complaint when we've extended the time frame to make a determination, and you disagree with this action, or when we've determined that your appeal doesn't qualify as an expedited appeal and you disagree.
- ☐ **Standard Appeal**- a request to the plan to reconsider how we cover or pay for your care.
- ☐ **Expedited Appeal**- a request you make when you and/or your doctor believes that waiting for a decision under the standard time frame could be a risk to your health.

Indicate what results you want to see:

Member Signature	Date (MM/DD/YY)

In signing this document, I am indicating that the information on this form, including any attachments is true and correct to the best of my knowledge. If I sign this as an authorized representative, it means that I have the legal right under the law to sign and I am able to procude proof if it is requested.