FLORIDA HEALTH SOLUTION CORP.

GRIEVANCE/APPEAL FORM

TODAY'S DATE:	DATE OF INCIDENT:	
ADDRESS		
CITY:	STATE:	ZIP CODE:
YOUR NAME:	MEMBER'S NAME (IF DIFFERENT):	I.D. #:
HOME PHONE #:	WORK PHONE #:	
GROUP/EMPLOYER NAME:	PRIMARY CARE PHYSICIAN/GENERAL PRACTITIONER	

Please explain grievance/appeal in full:_____

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SIGNATURE OF MEMBER (OR MEMBER'S LEGAL REPRESENTATIVE IF APPLICABLE): DATE

Please submit any paid receipts, claims or other pertinent information to help expedite solving this matter.
All information provided will be held in strict confidence