FLORIDA HEALTH SOLUTION CORP.

GRIEVANCE/APPEAL FORM

TODAY'S DATE:	DATE OF INCID	DATE OF INCIDENT:		
ADDRESS	I			
CITY:	STATE:	ZIP	ZIP CODE:	
YOUR NAME:	MEMBER'S NAME (IF DIFF	ERENT):	I.D. #:	
HOME PHONE #:	WORK PHONE	# :	<u> </u>	
GROUP/EMPLOYER NAME:	PRIMARY CAR	PRIMARY CARE PHYSICIAN/GENERAL PRACTITIONER		
Please explain grievance/appeal in full:	<u> </u>			
				
				
SIGNATURE OF MEMBER (OR MEMBER'S LEGA	AL REPRESENTATIVE IF APP	LICABLE):	DATE	
Please submit any paid receipts, clain	ms or other pertinent inf	ormation to	help expedite solving	g this matter.