

AGENCY FOR HEALTH CARE ADMINISTRATION

Subscriber Assistance Program

**Quarterly Report Of Subscriber Grievances
Non-Grandfathered Plans**

Managed Care Entity: _____

Address: _____

City: _____ Zip: _____

Reporting Contact: _____ Phone: (____) _____

Reporting Period: **Year:** _____

- _____ January 1 to March 31
- _____ April 1 to June 30
- _____ July 1 to September 30
- _____ October 1 to December 31

Report should be submitted
on a *calendar* quarter not
a fiscal quarter.

A - Total number of formal subscriber grievances ***not resolved*** to the full satisfaction of the subscriber ***after completion of the entire grievance process***: _____

B - List each subscriber grievance included in "A" above (attach additional pages if necessary).

| | <u>Subscriber Name, Address and Telephone Number</u> | <u>Nature of Grievance</u> <small>(Authorizations, Out of Plan Services, Reimbursement, etc.)</small> | <u>Contract Type</u> <small>(Commercial, Medicare, EPO, Medicaid, PPO, etc.)</small> |
|----|--|--|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

| | | | |
|-----|--|--|--|
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |

C - List all outstanding grievances included in item B, above, that are being resolved through the Federal External Review process or arbitration (attach additional pages if necessary).

| | <u>Subscriber Name</u> | <u>Date Original Grievance Received</u> | <u>Date Submitted For Arbitration</u> |
|----|------------------------|---|---------------------------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| | | | |

D - List all outstanding grievances included in item B that are being litigated in court (attach additional pages if necessary).

| | <u>Subscriber Name</u> | <u>Date Original Grievance Received</u> | <u>Date Litigation Began and Case Number</u> |
|----|------------------------|---|--|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

The information contained herein is true and correct to the best of my knowledge.

Signed: _____ Date: _____

Title: _____

Send report to:

Subscriber Assistance Program
 Agency for Health Care Administration
 2727 Mahan Drive, Mail Stop 26
 Tallahassee, FL 32308

Form may be accessed online at: <http://ahca.myflorida.com/MCHQ/Consumer/SPSAP/forms.shtml>

**ADDENDUM FOR ADDITIONAL ENTRIES FOR SECTION B ABOVE:
List each subscriber in "A"**

| | <u>Subscriber Name, Address and Telephone Number</u> | <u>Nature of Grievance</u> (Authorizations, Out of Plan Services, Reimbursement, etc.) | <u>Contract Type</u> (Commercial, Medicare, EPO, Medicaid, PPO, etc.) |
|-----|--|---|--|
| 16. | | | |
| 17. | | | |
| 18. | | | |
| 19. | | | |
| 20. | | | |
| 21. | | | |
| 22. | | | |
| 23. | | | |
| 24. | | | |

| | | | |
|-----|--|--|--|
| 25. | | | |
| 26. | | | |
| 27. | | | |
| 28. | | | |
| 29. | | | |
| 30. | | | |
| 31. | | | |
| 32. | | | |
| 33. | | | |
| 34. | | | |
| 35. | | | |
| 36. | | | |