

**AGENCY FOR HEALTH CARE ADMINISTRATION  
SUBSCRIBER ASSISTANCE PROGRAM  
Managed Health Care Plan Response Form**

**\*\*\*Please note, you *must* fill out this *entire* form. Any empty sections will delay the processing of this grievance. Also be sure to sign and date where indicated.**

Managed Health Care Plan: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(P.O. Box or Street & Suite Number)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(City) (County) (State) (Zip Code)

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Mailing Address: \_\_\_\_\_

(P.O. Box or Street & Apartment #, City, State, Zip Code)

Name on Subscriber's contract, if different than Subscriber: \_\_\_\_\_

Group Number: \_\_\_\_\_ Member Number: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group Size: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Please select one of the following:

- Commercial-not subject to Fed. External Rev.  Medicaid  Medicaid Reform  Medicare  
 Other \_\_\_\_\_

**Indicate Plan Category:**

- \_\_\_\_\_ Health Maintenance Organization  
\_\_\_\_\_ Exclusive Provider Organization (EPO)  
\_\_\_\_\_ Prepaid  
\_\_\_\_\_ EPO with Point of Service  
\_\_\_\_\_ EPO with Indemnity  
\_\_\_\_\_ Provider Service Network  
\_\_\_\_\_ Other: \_\_\_\_\_

**Indicate Nature of Grievance:**

- \_\_\_\_\_ Quality of Care  
\_\_\_\_\_ Formulary  
\_\_\_\_\_ Medical Necessity  
\_\_\_\_\_ Pre-Existing Condition  
\_\_\_\_\_ Excluded Benefit  
\_\_\_\_\_ Financial (billing, contract coverage, etc.)  
\_\_\_\_\_ Eligibility (Enrollment/Disenrollment)  
\_\_\_\_\_ Non-authorized services  
\_\_\_\_\_ Out-of-Network services  
\_\_\_\_\_ Experimental/Investigational/Unproven  
\_\_\_\_\_ Other: \_\_\_\_\_

Describe the Subscriber's grievance (use additional pages if necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Investigation involved and findings: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Identify by statute and/or contract provision, justification for the final disposition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How would the Health Plan like to see this matter resolved? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have all levels of the Health Plan's grievance procedure been completed?     \_\_\_ Yes     \_\_\_ No

Were the Department of Financial Services/Office of Insurance Regulation or the Agency for Health Care Administration previously involved in this grievance complaint?     \_\_\_ Yes     \_\_\_ No

Has this grievance been submitted to an arbitrator for resolution?     \_\_\_ Yes     \_\_\_ No

Has this grievance been litigated in any court of law?     \_\_\_ Yes     \_\_\_ No

If applicable, has beneficiary requested a Medicaid Fair Hearing?     \_\_\_ N/A     \_\_\_ Yes     \_\_\_ No

Please complete this form and provide all pertinent documentation required which will support the health plan's denial. Return to:

Agency for Health Care Administration  
Subscriber Assistance Program  
2727 Mahan Drive, Mail Stop 26  
Tallahassee, Florida 32308  
Fax: (850) 413-0900

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print / Type Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_