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 ☐ Medicaid ☐ Medicaid Reform ☐ Medicare ☐ Other: _________

Indicate Plan Category:
________ **H**ealth **M**aintenance **O**rganization
________ **E**xclusive **P**rovider **O**rganization (EPO)
________ Prepaid Health Clinic
________ EPO with Point of Service
________ EPO with Indemnity
________ **P**rovider **S**ervice **N**etwork
________ 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 herin is true and correct to the best of my knowledge.

Signature: ____ **Date:** ______________

Print / Type Name: ____

Title: ____