AGENCY FOR HEALTH CARE ADMINISTRATION
SUBSCRIBER ASSISTANCE PROGRAM
Request for Review and Release Form

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

I hereby appeal to the Subscriber Assistance Program to review and hear a grievance against _____ (Managed Health Care Plan) in accordance with Section 408.7056, Florida Statutes.

Subscriber Name: _____

Sex (circle one): Male Female Date of Birth:_____

Subscriber Mailing Address: _____
(P.O. Box or Street & Apartment Number)

_____ , _____ , _____ , _____
(City) (County) (State) (Zip Code)

Home Phone: ( )_____ Work Phone: ( )_____

Email Address: _____ Fax Number: ( )_____

Name on Health Plan contract, if different than Subscriber: _____

Group Number: _____ Member Number: _____

Medicaid beneficiary? _____ Yes _____ No

Healthy Kids beneficiary? _____ Yes _____ No

Medicare beneficiary? _____ Yes _____ No

Primary Care Physician (PCP): _____ PCP Phone: ( )_____

Physician associated with the grievance, if any: _____

Associated physician's phone number: ( )_____

Indicate Nature of Grievance:

1. ____ Health Benefits/Services
2. ____ Medical Necessity
3. ____ Formulary
4. ____ Eligibility (Enrollment)
5. ____ Financial (Billing, contract coverage, etc.)
6. ____ Quality of Care
7. ____ Other_____

Describe your grievance (use additional pages if necessary): _____

AHCA Form 3160-0007, Rev March-09

_____
_____
_____

How would you like to see this matter resolved? _____
_____
_____
_____

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

Is the grievance being litigated in any court of law? ____ Yes ____ No

If applicable, have you requested a Medicaid Fair Hearing? ____ N/A ____ Yes ____ No

Guidelines for submitting documentation:

- Documents should be provided in chronological order on loose, single-sided letter sized (8 ½" x 11") paper and grouped with paper clips, rubber bands, section dividers, etc.
- Documents should NOT be stapled together, in plastic sheet covers, have any kind of spiral binding or be in notebooks.
- We do NOT accept DVDs, cassettes, etc.

NOTE: All documents previously submitted to the health plan during its internal grievance review will be provided to us by your health plan. Documentation generally submitted to us by the health plan are the contract, handbook, correspondence, medical research information (if any), authorization requests, etc. Therefore, you do not need to send those to the Subscriber Assistance Program.

Please complete this form and attach all pertinent documentation which will support your grievance. Return to:

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

I am willing to furnish any information requested by the Agency for Health Care Administration and the Subscriber Assistance Program and grant release of my medical records to the Subscriber Assistance Program, the Agency for Health Care Administration, the Department of Financial Services, Managed Care Organization, and any other state or federal agency deemed necessary by the Agency for Health Care Administration.

The information contained above is true and accurate to the best of my knowledge. A copy of this grievance may be provided to the managed health care plan involved.

Signature: _____ **Date:** _____

Print Name: _____