ASPIREHEALTHPLAN

Appeal & Grievance Form

This form is for your use. You can file a grievance (complaint) or request an appeal regarding denied care/service or denied payment. Aspire Health Plan **is required by law** to respond to your complaints and appeals. We have an outlined procedure that exists for resolving these situations. If you have any questions, please feel free to call the Member Services department toll free at 855-570-1600 or via TDD/TTY 711 for the hearing-impaired.

Please print or type the following information:

Member Name (Last, first, middle initial): _____

Member ID: _____

Address: _____ City, State, Zip _____

Home Phone number: _____ Cell Phone number: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:

Name: _____ Relationship to Member: _____

Address: _____ City, State, Zip _____

Home Phone number: _____ Cell Phone number: _____

Please describe your ☐ complaint or ☐ appeal. It's helpful if you can give dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

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Please sign and MAIL or FAX TO the health plan:

By mail:

Aspire Health Plan
Appeals & Grievance Department
10 Ragsdale Drive, Suite 101
Monterey, CA 93940

Fax: 831-657-0703

Federal Express:

Aspire Health Plan
Appeals & Grievance Department
10 Ragsdale Drive, Suite 101
Monterey, CA 93940

Date_____ Signature_____

Date_____ Signature of Representative_____
(Note, if representative, need Appt. of Rep form)