**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 complete the portion below:**

Name: ___________________________________ Relationship to Member: ___________________________

Address: ___________________________________ City, State, Zip _________________________________

Home Phone number: ___________________________ Cell Phone number: ___________________________

Please describe your □ complaint or □ appeal. Please include the following information: 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)

Aspire Health Plan is an HMO plan sponsor with a Medicare contract. Enrollment in the Plan depends on contract renewal. Aspire Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-570-1600 (TTY: 711) 注意：如果您使用繁體中文，您 可以免費獲得語言援助服務。請 致電1-855-570-1600（TTY：711）