



Part C and Part D Grievances Form

This form is for your use in filing a formal grievance regarding any aspect of the care or service provided to you. Your health plan **is required by law** to respond to your complaints. If you have any questions, please feel free to call Customer Services 1-866-688-9021.

Please print or type the following information:

Member Name	Medicare Number
Address	Member ID #
City, State, Zip	Phone Number
Name of Employer or Group	Enrollment ID #

Date of Birth _____
Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file a Grievance" and provide the following information:

Name: _____ Telephone #: _____

Relationship _____ to
Member: _____

Address: _____

City: _____ State: _____ Zip: _____

Please state the nature of the complaint – giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

Please sign and MAIL or FAX TO your health plan (see page # 2 for health plan address)

Date _____ Signature _____

Date _____ Signature of Representative _____



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Send your Member Appeal and/or Grievance Letter to your health plan at:

Health Plans: Astiva Health	Phone/Fax
Attn: Grievance & Appeals 765 The City Drive South, #20 Orange, CA 92868	1-866-688-9021 TTY: 711 Member Services, Times Monday to Friday 8:00 a.m. to 8:00 p.m. (except Thanksgiving and Christmas) Fax: 657- 208-7551

Who May File a Grievance?

You or someone you appoint to act on your behalf may file a grievance. You can appoint a relative, friend, advocate, attorney, doctor, or someone else to act for you. Or others; not previously mentioned may already be authorized under State law to act for you.

You can call us at: 1-866-688-9021 to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY: 711

If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

For more information, please contact Astiva Health Member Services at 1-866-688-9021, TTY: 711 Monday – Friday, 8:00 a.m. – 8:00 p.m. (except Thanksgiving and Christmas)