RETURN TO:

Simply Healthcare Plans, Inc.
Attn: Grievance Coordinator
P.O. Box 830010
Miami, Fl. 33283

Fax# 305-408-5765

GRIEVANCE AND APPEAL FORM

Member Name: _____ Member Date of Birth: _____

Member ID #: _____ Member Phone #: _____

Member Address: _____

Primary Care Doctor's Name : _____

1. Please explain your grievance or appeal issue:

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2. Please state your request. How would you like Simply Healthcare Plans, Inc. to resolve your issue?

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Signature: _____ Date: _____