Molina Healthcare

Member Grievance/Appeal Request Form

Please Print

Member's name: _____Today's date: _____

Name of person requesting grievance, if other than the Member: _____

Relationship to the Member: _____

Member's ID #: _____ Daytime telephone _____

Specific issue(s):

_____

_____

_____

_____

(Attach another sheet of paper to this form if you need more space)

Member's Signature _____ Date: _____

If you would like assistance with your request, we can help. You can call or write to us at:

Toll free: (866) 472-4585
Molina Healthcare of Florida
Attn: Grievance & Appeal Department
8300 NW 33rd Street, Suite 400
Miami, FL 33122

Fax Number: (866) 422-6445

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