M9A69F GRIEVANCE FORM

Date_____________

Member (Cardholder) Name____

Dependent Name (If applicable) ____

Member Telephone ____

Member Address_____________________________________

City, State, Zip _____________________________________

Member Identification Number_________________________

Member Group Name/Employer________________________

Please be specific and check all areas that apply. Please state the nature of your complaint; give date(s), time(s), person(s), place(s), billed amount(s) etc. If any attempt was made to resolve the situation, please indicate details. You may attach an additional page if necessary.

_____ physician _____ service _____ pharmacy

_____ office staff _____ enrollment _____ benefits

_____ hospital _____ claim payment _____ other (specify)

_____ eligibility _____ medical care

Please describe your complaint/problem

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____ __________________________

Member's Signature Date

HealthLink Members Mail Complaint Form To:
HealthLink
P. O. Box 411424
St. Louis, MO 63141

Telephone: 1-800-624-2356 or (314) 925-6000
Facsimile: (314) 925-6637