Antidote Health Plan of Arizona, Inc.
Antidote Health Plan of Ohio, Inc.

Member Grievance, Appeal or Concern Form

We value your feedback and are committed to addressing any concerns you may have. Use this form to file a complaint (grievance), ask for a decision to be reviewed (appeal) or share a concern. **Filling out this form is optional,** and if you need help, Member Services is here to assist. Someone will contact you by phone when this form is received.

Please return the completed form to: Attn: Member Services, Antidote Health Plan
PO Box 39638
Solon, OH 44139

You may also fax it to 1-347-296-3528 or file your grievance, appeal or concern verbally with Member Services at 888-623-3195, 8am – 8pm ET, Monday – Friday (TTY/RTT 711).

Section 1 – Member Contact Information

NAME OF MEMBER:	MEMBER ID:	DATE OF BIRTH:
ADDRESS:		
PREFERRED PHONE NUMBER:	EMAIL ADDRESS:	TRACKING/DENIAL NUMBER:

Section 2 – Contact Information for Guardian or Non-Grieved Party

NAME OF GUARDIAN OR INDIVIDUAL FILING, IF DIFFERENT FROM MEMBER:	RELATIONSHIP:
EMAIL ADDRESS:	PREFERRED PHONE NUMBER:

Section 3 – Explanation of Issue

Describe the problem in detail:	
What would you like someone to do about the problem?	
Will you need language assistance? ☐ Yes ☐ No	If yes, language preference:
Do you require medical attention within the next three days or are you in severe pain? ☐ Yes ☐ No Please describe:	
Is this grievance related to the termination of medical coverage? ☐ Yes ☐ No If yes, provide date Member received notice that coverage was or will end: ______________________________	
Please provide any supporting documents with this form, such as plan notice(s) and correspondence(s), billing statements, and proof of payment. You must file an appeal within 180 calendar days of the date of the denial letter. You must file a grievance within 180 calendar days of the date of the event.	
SIGNATURE*:	DATE:

***Ohio Only:** If signed by someone other than the Member, an Authorized Representative Form is required.
Arizona Only: A member, provider or an Authorized Representative may fill out and sign this form.