Appeal/Grievance (Complaint) Request Form

- **Appeal:** If there is belief FHP did not cover or pay enough for a service or drug received.
- **Grievance:** If there is a complaint against FHP or your health care provider.

Who is the appeal or grievance for? *Please provide member ID#, Name, DOB, address	
Who is requesting the appeal or grievance? *Name and contact information (If different than above)	
Phone:	**Fax (if applicable):**
Communication by email is OK: ☐ **Email address (if box to the left is checked):**	
If you have given Friday Health Plans appropriate consent for an Individual to act on your behalf, Friday Health Plans will send response acknowledgement/appeal or complaint correspondence to that individual.	
What is your appeal or grievance about? (Please add detail below).	☐ My claim or coverage was denied. ☐ I disagree with FHP's payment ☐ Other (Please specify)
Type of service, service date, billed amount, claim #, authorization # (if applicable)	
Are you requesting an urgent appeal? ("urgent" means your life, health, or ability to maintain function is in jeopardy.) ☐ **Yes** ☐ **No**	
Briefly describe your dissatisfaction or why you disagree with our decision not to approve the requested service/benefit (you may attach additional information such as a physician's letter, bills, medical records, or other documents to support your claim):	

Send this form, your denial notice, and any supporting documentation to:

Friday Health Plans ATTN: Appeals and Grievances
700 Main St.
Alamosa, CO 81101
Ph: 1-844-451-4444
Fax: 1-844-280-1794
Email: appeals@fridayhealthplans.com

Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.