

MEMBER GRIEVANCE FORM

Member's Name _____ Member's Date of Birth _____

Member's ID Number _____ Member's Medical Records # _____

Name of member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

Date of Incident _____

Contact Phone Number _____

Person(s) or Provider(s) Involved _____

Describe what happened:

Signature _____

Of Member or Member's Designated Representative/Guardian

Date _____

Please send to: **Friday Health Plans of Colorado**
Attn: Grievance and Appeals Department
700 Main Street, Suite 100
Alamosa, CO 81101
Phone: 719-589-3696



Call us at 1-800-475-8466 or 719-589-3696 if you need help or have questions