Grievance, Reconsideration and Appeal Request Form

Please complete the form below with information about member's grievance/reconsideration/appeal.

Member Name:
Member ID #:
Authorized Representative*:
Phone Number:
Address:
Claim Number
Date(s) of Service
Name of Provider

Please explain your appeal, grievance, or complaint in this section. You can attach extra information to support your grievance/reconsideration/appeal.

919 Hidden Ridge | Irving | TX 75038
Tel 800.678.7347 | Fax 210.766.8851 | USFHPEnroll.com

Grievance and Appeal Request Form

*An Appointment of Representative (AOR) form or other equivalent written notice is required when someone files an appeal/grievance on behalf of a member. Please call us if you need an Appointment of Representative (AOR) form sent to you.

Signature of Member or Representative

Date

Relationship to Member (If Representative)

Mail this form to the following address for a timely appeal/grievance resolution:

US Family Health Plan
Complaint, Appeal, and Grievance Department
PO Box 169009
Irving, TX 75016
Fax: **1.866.416.2840**

If you have any questions, please contact Member Services at **1.800.678.7347**, **TTY 711**. We are open Monday through Friday from 8 a.m. to 5 p.m. (Local Time). Our automated phone system will answer your call after 5 p.m. Monday through Friday, and on Saturdays, Sundays and some public holidays. Please leave your name and telephone number and we will call you back by the end of the next business day.