

As a Highmark Health Options member, if you are unhappy about a service you received or a medical provider, you can ask for a grievance. You can have a legal or acting representative help with your grievance. A grievance is a statement of unhappiness because of a limited health care service. This includes the:

- Type or level of service.
- Reduction, suspension, or termination of a service.
- Failure to provide a service in a timely manner.
- Highmark Health Options' denial to pay in whole or in part for a service.

Find more information in a document called "Notice of Adverse Benefit Determination" that was mailed to you.

How to submit this form: Use the enclosed reply envelope to mail the completed form. If you do not have a reply envelope, mail to:
Highmark Health Options West Virginia
Attn: Appeals and Grievances
614 Market Street
Parkersburg, WV 26101

What happens next: We will send you a letter letting you know we received your form. We will review the information you have sent to us.

Use this form to consent to a legal or acting representative to help with your grievance.

Please fill in as much of the form as you can and include as much information as possible.

Be prepared to provide the following:

Member information: Find this on your member ID card.

Member's legal or acting representative: Provide information about the person you want to have as your representative.

Service/claim information: Tell us about the service, claim, or item about which you have the grievance. Find this information on the "Notice of Denial" letter.

Description of grievance: Tell us why you have a grievance. Use additional paper if necessary.

Signatures: Sign the form or have your representative sign the form.

Need help?

Call Member Services at 1-833-957-0020 (TTY:711) or read about the grievance process in your Member Handbook.

Member Information		
Today's Date	Member ID Number	Date of Birth
First Name	Last Name	Primary Phone Number
Street Address		
City, State, ZIP		

Member's Legal Representative <small>If applicable.</small>		
First Name	Last Name	Primary Phone Number
Street Address		
City, State, ZIP		

Member's Acting Representative		
First Name	Last Name	Primary Phone Number
Street Address		
City, State, ZIP		

Service/Claim Information	
Claim Number(s)	Reference/Authorization Number(s) <small>If applicable.</small>
Provider Name	Date(s) of Service(s)

Brief description of services that you are unhappy about

Understanding Your Rights

I, or my legally appointed representative if I am under age 18 or legally incompetent, authorize the above-named acting representative to file a grievance on my behalf with Highmark Health Options. I understand the following:

1. I may not submit a grievance concerning the services/items listed in this consent form unless I or the above-named acting representative rescinds authorization in writing. I have the right to rescind authorization at any time during the grievance process.
2. I have read, or have been read, this authorization form and have had it explained to my satisfaction.
3. The information in the authorization form grants my consent to the above-named acting representative to file a grievance on my behalf.

Member Printed First and Last Name	Signature	Date

If the member is under age 18 or unable to sign:

Representative Printed First and Last Name	Signature
Relationship to Member	Date: