

Member grievance (complaint) form

Directions:**Fax or mail a completed form and backup information to:**

Fax: (718) 536-3358
Attention: Appeals & Grievances Department
Mail: Affinity by Molina Healthcare
Attn: Appeals & Grievances Department
2900 Exterior St.
Suite 202
Bronx, NY 10463

If you would like help with your request, you can call or write to us

Phone: (800) 223-7242
Mail: Affinity by Molina Healthcare
Attn: Appeals & Grievances Department
2900 Exterior St.
Suite 202
Bronx, NY 10463

If you are not the member, give us your name. Please fill out and sign the "Appointment of Representative Form" attached. You don't have to use this form. If so, you can send us a written and signed letter by the member.

Today's date: _____**Type of coverage (select):**

- | | |
|---|--|
| <input type="checkbox"/> Medicaid Managed Care | <input type="checkbox"/> Child Health Plus |
| <input type="checkbox"/> Molina Healthcare PLUS | <input type="checkbox"/> Essential Plan 1 |
| <input type="checkbox"/> Essential Plan 2 | <input type="checkbox"/> Essential Plan 3 |
| <input type="checkbox"/> Essential Plan 4 | <input type="checkbox"/> Essential Plan 1 Plus |
| <input type="checkbox"/> Essential Plan 2 Plus | |

Member Last Name: _____ Member First Name: _____

Member Date of Birth: _____ Member ID/CIN#: _____

Relationship to the Member: _____

Daytime Phone Number: (____) _____

Specific Issue(s): If you need more space, you can send us another paper.

Member's Signature: _____ Date: _____

Member grievance (complaint) form

How to file a grievance (complaint):

1. Fill out this form. Tell us the issue(s) as best as you can.
2. You may want to send us copies of your records. If so, please send it with along with this form. (Do Not Send Originals).
3. You may give us your info in person. To do this, call us at (800) 223-7242.
4. We can help you write your request. We can help you in the language you speak. If you need services for the hard of hearing, you may call our TTY phone number at 711.
5. If you are 18 and over, and have someone else acting on your behalf, an Appointment of Representative (AOR) Form is needed. We will check our files to see if you have already been approved. You can also send us a written and signed letter, letting the person act on your behalf in place of the (AOR) Form. Molina Healthcare gives you an "Appointment of Representative Form" for your benefit. Please use the AOR that is attached or send us a written and signed letter.
6. We will still work the grievance (complaint) but the info will not be sent to you until you are approved by the Member. If we do not receive any kind of approval, the decision will be sent only to the member.
7. You may want to see the case file. You can ask to see or get copies of the case file at any time. This is free. Your file can have all of your medical records. It can also have any other papers about to your case.
8. You may have let someone act on your behalf. If so, they can also go over your grievance (complaint) file.
9. Fill out and send to:
Fax: (718) 536-3358
Attention: Appeals & Grievances Department

Mail: Molina Healthcare of New York, Inc.
Attn: Appeals & Grievances Department
2900 Exterior St.
Suite 202
Bronx, NY 10463
10. We will send you a letter. The letter will let you know we got your request.

Thank you for using the Molina Healthcare Member Grievance Process.



Appointment of representative (AOR) form

Member Name: _____

Molina Member ID Number: _____

Appointment of representative

I agree to name _____ (Name and address) to act on my behalf for a grievance/appeal for _____ (specific issue).

I approve this person to make or give any request or notice for me. This person can present or show any facts or evidence. This person can also get info on any past, present or future treatments, testing, evaluations, drugs, diagnosis, and results. This person can also talk about all my medical care or services. This person can also talk about my claims or bills I may have received. In addition this person can receive any notice about my pending grievance or appeal.

SIGNATURE (Member): _____

ADDRESS:

TELEPHONE NUMBER: (_____) _____

DATE: _____

Acceptance of appointment

I, _____, agree to the above. I confirm that I have not been suspected or banned from practice before the Social Security Administration. I am not a current or former officer or employee of the United States disqualified as acting as the members' representative; that I will not charge or get any fee(s) for the representation unless it has been approved in agreement with the laws and regulations.

I am a/an _____ (Attorney, union representative, relative, etc.)

SIGNATURE (Representative): _____

ADDRESS:

TELEPHONE NUMBER: (_____) _____

DATE: _____