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):

- ☐ Medicaid Managed Care
- ☐ Molina Healthcare PLUS
- ☐ Essential Plan 2
- ☐ Essential Plan 4
- ☐ Essential Plan 2 Plus
- ☐ Child Health Plus
- ☐ Essential Plan 1
- ☐ Essential Plan 3
- ☐ Essential Plan 1 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: _____

Affinity BY MOLINA HEALTHCARE

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. Affinity by 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: Affinity by Molina Healthcare
   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 Affinity by Molina Healthcare Member Grievance Process.

Affinity
BY MOLINA HEALTHCARE

Appointment of Representative (AOR) Form

Member Name: _____

Affinity by Molina Healthcare 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: _____

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