Grievance or Appeal Form

If you have a grievance or appeal related to your CarePlus plan or any aspect of your care, we want to hear about it. You can use this form to tell us what happened and let us know how we can help. Please provide complete information, so we can address your issue.

This form, along with any supporting documents (such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your doctor), may be sent to us by mail or fax:

Address: CarePlus Health Plans
11430 NW 20th Street, Suite 300
Miami, Florida 33172
Attn: Grievance & Appeals Department

Fax Number: 1-800-956-4288

If you need assistance with this form, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

1 Who is the member?

Member name (first and last)		
CarePlus member ID number		Member birthdate (MM/DD/YY)
Street address		City
State	Zip code	Phone number (with area code)

2 What is the issue?

For a specific medical service or medication, please provide the details below:

Medical service/medical equipment or medication	
Provider (Physician, Facility, Prescriber)	
Provider phone number (with area code)	Provider fax number
Is this a request for reimbursement? ☐ Yes ☐ No **If yes, please include a copy of the bill, receipt or proof of payment (receipts).*	
Service date(s) (MM/DD/YY) **N/A if care has not been received*	Claim number (if you have one)

2 What is the issue? *(Continued)*

What should we know about this issue? Please be as specific as possible about what happened and who was involved. Include any dates of service or contact with CarePlus employees, healthcare providers or pharmacies. If you run out of room, feel free to write on the back or add an extra page.

What additional information can you share? Please attach copies of any supporting information or documents that we should review, such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your provider.

What documents have you attached?

- ☐ Explanation of Benefits
- ☐ Medical bill(s)
- ☐ Medical records
- ☐ Receipts (Proof of Payment)
- ☐ Letter from your provider
- ☐ Other _____

Does your appeal need to be expedited? If you or your physician/prescriber believe that waiting for a standard decision (7 calendar days for a Part B/Part D prescription drug appeal or 30 calendar days for a medical pre-service/equipment appeal) could seriously harm your life, health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician or prescriber indicates that waiting for a standard decision could seriously harm your health, we will automatically give you a fast decision. If you do not obtain your physician or prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You *cannot* request an expedited appeal if you are asking us to review a service or drug you already received.

☐ Please check this box if you believe you need an expedited decision within 72 hours. If you have a supporting statement from your physician or prescriber, attach it to this request.

3 Do you need to appoint a representative?

Skip this section if you are the member acting on behalf of yourself.

If you are not the member and aren't sure if you're authorized to work with CarePlus on the member's behalf, please complete the Appointment of Representative (AOR) Form CMS-1696, which can be found on the CarePlus' website at https://www.careplushealthplans.com/members/forms-tools-resources or requested by contacting Member Services at 1-800-794-5907; TTY: 711. Both you and the member must sign and complete the AOR Form. If you are already legally authorized to act as the member's representative under state law, please attach the appropriate documentation so we can review (for example: court appointed guardian, Durable Power of Attorney, health care proxy, etc.).

4 Sign and Submit

Member Signature (or physician/prescriber) (optional)	Date
Member Printed Name (or physician/prescriber)	

OR

Authorized Representative Signature *(Only if you filled out the AOR form or attached other legal documentation)*	Date
Authorized Representative Printed Name	

Thanks for taking the time to inform us of this issue. We'll be in touch with you if we have any questions, and we'll get back to you as soon as we complete our review of the issue.

CarePlus Health Plans, Inc. complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Any inquiries regarding CarePlus' non-discrimination policies and/or to file a complaint, also known as a grievance, please contact Member Services at 1-800-794-5907 (TTY: 711).

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.