SOLIS HEALTH PLANS
A new dawn in healthcare

GRIEVANCE/APPEAL REQUEST FORM

PLEASE PRINT OR TYPE

Member 's Name: _____Date of Birth: _____

Member's Address: _____City: _____ State: ____ Zip Code: _____

Home Telephone: _____

Member ID # (listed on you Member ID card): _____

Date(s) of Service/Occurrence: _____

Provider Name (If Applicable): _____

Below please explain your grievance/appeal, please include any information you feel should be considered in the review of your grievance/appeal. Use additional sheet(s) if necessary. Please attach any document(s) that you feel should be reviewed. Complete, sign, and mail this request back to the address listed on this form. You can also fax it to the number listed on this form.

REQUEST FOR REVIEW

I HEREBY request a review of the grievance/appeal described above and understand that the receipt of this Grievance/Appeal Form by SOLIS constitutes a request for review. I understand that for SOLIS to review my grievance/appeal, SOLIS may need medical or other records or information relevant to my grievance/appeal. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me to release such information to SOLIS for SOLIS to complete its review of my grievance/appeal. This information will not be released to any other organization or individual except as permitted under Federal and State Law, pursuant to court orders or subpoenas. SOLIS has established appropriate safeguards to ensure the privacy and confidentiality of all medical information and to prevent unauthorized access to it.

Member (or Authorized Representative*)
Signature: _____ Date: _____
If you are the authorized representative, you must sign above and provide the following information:
Name: _____
Relationship to Member: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____

*Authorized representatives must attach a copy of the "Appointment of Representative" (AOR) Form or other appropriate legal documentation supporting the authorized representative status. Examples of appropriate legal documentation include a Durable Power of Attorney for Health Care Decisions, a Health Care Surrogate, etc. You may request the "Appointment of Representative" form from our Member Services department. This form is also available on the Medicare website at www.cms.gov/cmsforms/downloads/cms1696.pdf or on the SOLIS website at www.SOLIShealthplans.com. The "Appointment of Representative" form must be signed by you and by the person you would like to act on your behalf. A copy of this form must be submitted to the plan.

Please mail or fax this signed form to:

SOLIS Health Plans
PO Box 524173
Miami, FL 33152
Attn: Grievance/Appeals department
Fax: 1-833-615-9263

Please note that your benefits will continue during this grievance/appeal if you remain enrolled in SOLIS. If you need assistance completing this form or have any questions regarding it, please call Member Services at 1-844-447-6547,TTY 711, from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30.

SOLIS Use Only

Received by: _____ Date received: _____

☐ By Mail Time received: _____

☐ By Fax

☐ By Telephone

☐ In Person

☐ Other _____

ATENCIÓN: Si usted habla español, están disponibles para usted, y sin cargo, servicios de asistencia lingüística. Llame al 1-844-447-6547, TTY 711, de 8 a.m. a 8 p.m., los siete días a la semana desde el 1 de octubre hasta el 31 de marzo y de 8 a.m. a 8 p.m., de lunes a viernes desde el 1 de abril hasta el 30 de septiembre.

SOLIS Health Plans, Inc. is an HMO plan with a Medicare contract. Enrollment in Solis depends on contract renewal.