MoreCare®
A Medical Home Network Affiliate

Grievance Intake Form

This form is for your use in filing a formal complaint/grievance regarding any aspect of the care or service provided to you as a member of the Health Plan. Please fill out the information as completely as possible and submit to the fax or address below. If you have any questions, please feel free to call the Customer Service department using the phone number that can be found on your member ID card.

Please print the following information:

Member Name (Last, first, middle initial) _____ Member ID Number _____

Address _____ Home Phone number _____

City, State, Zip _____ Mobile or Work Phone number _____

Date of Birth _____

Authorized Representative: *If the complaint is filed by someone other than the member, please provide the following information (NOTE: To be an authorized representative, a completed Appointment of Representative (AOR) is required; AOR forms are available on the website.) :*

Name:_____ Telephone #: _____

Relationship to Member: _____

Address:_____

City: _____ State: _____ Zip: _____

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

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Please sign and **MAIL** or **FAX** TO the contacts below:

Date_____ **Signature**_____

Date_____ **Signature of Representative**_____

Address: MoreCare
Attn: Grievance and Appeals
P.O. Box 21994
Eagan, MN 55121

FAX: 1-888-345-9110