



GRIEVANCE FORM

Request for Standard Grievance **Request for Expedited (fast) Grievance**

Last Name: _____ First Name: _____ Middle Initial: _____

Home Address: _____ Apt/Lot #: _____

City: _____ State: _____ Zip: _____

Contact Telephone: _____ Freedom Health ID#: _____

Date(s) of problem (s) occurred: _____

Location where problem(s) occurred: _____

Problem occurred as follows (please be as specific as possible, include time, sequence of events, all subsequent events, etc. Use additional sheets of paper if necessary):

Action requested as follow-up to problem:

Member Signature _____

Date _____

NOTE: Freedom Health will contact you within five (5) working days to acknowledge the receipt of this grievance. Your benefits will continue during the course of this grievance as long as you remain enrolled as a member in Freedom Health.

You can call us at 1-888-796-0947 (TTY 1-800-955-8771)

Or you can fax this form to 813-506-6235

You can mail this form to: Freedom Health, Inc., Attn: Grievance and Appeals
Department, P.O. Box 152727, Tampa FL, 33684

You can hand-deliver this form to: Freedom Health, Inc. 5403 N. Church Ave, Tampa FL 33614