Do Not Use this Form to submit an Appeal

Provider Grievance Form

Request Date: _____

Provider Information:

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Member Information: (list separately)

Name: _____

ID#: _____

Date of Birth: _____

Service Provided Information:

Date(s) of Service: _____

Place of Service: _____

Please check a complaint reason(s).

____Administration
____Health Care Delivery
____Provider Reimbursement
____Contracting
____Other

Explanation of Issue(s):

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to ProviderGrievances@freedomh.com or via fax to (813) 490-5303. You may also submit documentation via mail to: Provider Grievances P.O. Box 151257 Tampa, FL 33684. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

Failure to submit supporting documentation may delay our response to your complaint.