

Grievance Form

Use this form to submit a formal complaint or grievance about anything other than a benefit or claim denial. If your grievance is regarding a benefit or claim denial, please use our Medical Appeal Form or Pharmacy Appeal form instead of this form.

Member Information			
First Name:		Last Name:	
DOB:		Member ID:	
Street Address:			
City:		Phone:	
State:	Zip:	Email (optional):	
Do you want us to contact you to follow up regarding this grievance? ☐ Yes ☐ No			
Preferred method of contact regarding this grievance: ☐ Phone ☐ Email ☐ Mail		Is this grievance urgent? ☐ Yes ☐ No	
Person Completing this Form (if different from member)			
First Name:		Last Name:	
Relationship to Member: ☐ Friend ☐ Family ☐ Authorized Representative ☐ Other			
Phone:		Email (optional):	

Grievance Information

Why are you filing a grievance?

What is your desired outcome with this grievance?

Consent

By signing below, I give St. Luke's Health Plan, Inc. permission to investigate this grievance, review associated medical records, and talk to my healthcare provider(s) about my grievance if necessary.

Member Signature*:

*Or the signature of the person authorized to act on your behalf under Idaho state law. If this form is signed by an authorized representative, this signature certifies that:

1. This person is authorized under Idaho state law to act on the member's behalf; and
2. Documentation of this authority is available upon request by St. Luke's Health Plan, Inc. or the Centers for Medicare and Medicaid Services (CMS).

Questions?

If you have any questions about this form, please call Customer Service at **833-840-1214 (TTY: 711)**. We are available October 1 to March 31, seven days a week, from 8 a.m. to 8 p.m. and April 1 to September 30, Monday to Friday from 8 a.m. to 8 p.m.

Send this completed form and any documentation you want to provide via email or mail:

Mail:

St. Luke's Health Plan
Attn: Appeals Department
PO Box 1739
Boise, ID 83702

Email: slplanappeals@slhealthplan.org