NJ FamilyCare

FIDELIS CARE®

Grievance Form

First Name: _____

Last Name: _____

Member ID#: _____

Best phone number to reach you: _____

Your email address: _____

What is the reason for your grievance (formal complaint)? Check the box for the issue that applies to you.

☐ **1.** Difficulty making an appointment

☐ **2.** Dissatisfaction with the way a provider or their staff treated me

☐ **3.** A provider refused to see me because of claims payment issues with the Plan

If you choose 1, 2, or 3 above, specify provider: _____

☐ **4.** Difficulty getting services authorized

☐ **5.** I was billed for covered services

☐ **6.** Dissatisfaction with the way Health Plan staff treated me

Additional Information (Optional): _____

_____

If we have denied your request for a treatment, item, or medication and you disagree with our decision, you can ask us to change it. That request is called an appeal. However, an appeal is different from a grievance. You can call us toll-free at **1-888-453-2534** (TTY: **711**) to file an appeal or if you have questions.

Have you contacted us before about this issue? ☐ Yes ☐ No

If yes, please give the date you contacted Member Services

Date: ____ /____ /_____

CAD_122892E State Approved 08302023
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