

CONSENT FOR PROVIDER TO FILE A GRIEVANCE FOR ENROLLEE

Provider name	Provider plan ID number
Provider address	
Description of specific service or item for which I agree the provider can file a grievance	Name and address of MCO where grievance will be filed

Name of enrollee	Enrollee's date of birth
Enrollee case record #:	
Enrollee mailing address	
Enrollee daytime telephone number	Enrollee evening telephone number

I, **[Name of Enrollee]**, agree that **[Name of Provider]** can file a grievance for me with **[MCO]** about the service or item described above.

By signing this consent form, I understand the following:

1. I or my representative may not file a grievance about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the grievance process by telling **[MCO Name]** and **[Name of Provider]** in writing that I do not want **[Name of Provider]** to continue the grievance process for me.

2. My consent to have the Provider file the grievance for me will no longer be in effect if the Provider does not file the grievance or does not continue with the Grievance through the end of the Grievance review process.

3. I or my representative has read, or has been read, this consent form, and have had it explained to me until I understand it. I or my representative understands the information in this consent form.

Signature of Enrollee or Representative

Date

Witness Signature

Date

Print Witness Name

If the Enrollee is unable to sign this consent form because the Enrollee is legally incompetent:

Name of Person Signing on Behalf of Enrollee

Address of Person Signing on Behalf of Enrollee

Relationship of Person Signing to Enrollee

This form can be sent to:

Fax number: **[MCO FAX #]**

Mailing address:

[MCO ADDRESS]