Received date: / / mm, dd, yy	**GRIEVANCE REQUEST FORM**

SECTION A: PERSONAL INFORMATION OF THE COMPLAINANT		
Name (PRINT)	Telephone Number	Contract Number
Address	Date Case Filed	Primary Physician or Provider Number (if applicable)
	PMG Number	Primary Physician or Provider phone number

SECTION B:	**GRIEVANCE FILED AGAINST**	
Name	Contract Number	Primary Physician Provider (if applicable)

SECTION C: DESCRIPTION OF THE EVENTS RELATED TO THE GRIEVANCE (Include documents that support your case) If you need additional space, please use new paper, and attach.

I certify that I or my authorized representative read the issues described above, and the information provided is correct, and I agree with it.

Provider, Member or Representative's Signature

Witness Signature (if applicable)

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SECTION D: GRIEVANCE CLASSIFICATIONS (to be complete by PSM)	
☐ 1. Access or Delay of Services	☐ 9. Inappropriate Behavior by Provider/Staff Member
☐ 2. Appointment Standard Availability/Timeliness	☐ 10. Network Availability of Services
☐ 3. Co-Pay/Deductible	☐ 11. Pharmacy
☐ 4. Customer Service Issue	☐ 12. In-Office Waiting Times
☐ 5. Dissatisfaction W/ PCP	☐ 13. Quality of Medical Service
☐ 6. Dissatisfaction W/ Contractor	☐ 14. Quality of Office/Facility (Equipment/Environment etc.)
☐ 7. Hazardous Environment	☐ 15. Services/Procedures Denied or Reduced
☐ 8. HIPAA violations	☐ 16. Other

Name of Customer Service Representative

Signature

**** Complete all the applicable fields and sign this form. You can deliver it at a Service Office near your home, send by regular mail, fax, or email (details below).**

INSTRUCTIONS: How to request a grievance or an appeal with PSM?

Step 1: You, your representative, or your physician acting on your behalf (authorized in written by you) can request a grievance or an appeal. Your *written* request must include:

- Your name, member ID, contract number, and address
- Reasons for your grievance or appeal
- Any evidence you want us to review, such as medical records, medical orders, or other information that explains why you need the item or service. Ask your physician for this information.

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How to Submit your Complaint, Grievance or Appeal:

Please submit this completed form by mail, by email, in person, or fax:

By Mail:
Attention: PSM-GHP Grievances
& Appeals Department
PO Box 364128
San Juan, PR 00936

By fax:
Attention: PSM Grievances &
Appeals Department
Tel. 787-332-0928

In Person:
to any of our Services Offices in Caguas, Fajardo, Guayama, Humacao, Ponce and Mayaguez. Please call our Service Line to know the location.

By email:
vitalgrievancesand appeals@planmenonita.com

You can use the attached form, or you may write a letter including all the details.

This form is available in our website www.menonitavital.com.

This format is available in alternative formats, such as large print, braille, or audio.

This form is also available in other languages, and PSM will provide oral interpretation services into any language other than English, if needed. Such translation is at no cost to you.

If you need more information, or assistance to file a Complaint, Grievance or Appeal, please call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). Available Monday through Friday from 7:00 AM to 7:00 PM. This phone call is free. Upon request, interpreter services are also available in the Puerto Rico Health Insurance Administration (ASES).

Contact information for the OPP:
Telephone: 787-977-1100 (Metro Area) 1-800-981-0031 (toll free) Fax: 787-977-0915

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Contact information for ASES:

Telephone: 787-474-3300 (Metro Area) 1-800-981-2737 (toll free) Fax: 787-474-3348

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüís-tica.

Llame 1-866-600-4753 (TTY: 1-844-726-3345)
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-600-4753 (TTY: 1-844-726-3345). al 1-866-600-4753 (TTY: 1-844-726-3345).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電（TTY: 1-866-600-4753 ; 1-844-726-3345）。
PSM cumple con las leyes estatales y federales aplicables de derechos civiles y no discrimina por razón de raza, edad, color, origen de nacionalidad, discapacidad o sexo.

Documento puede estar disponible en formatos alternativos como letra grande, audio u otros idiomas. Si necesita recibir estos servicios, llame al 1-866-600-4753 y 1-844-726-3345 TTY (audioimpedidos).

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