Grievance Appeal Form

Member name: _____

Member date of birth: _____

Member identification number: _____

Grievance date: _____

Grievance issue: _____

Date of the Notice of Grievance determination letter: _____

Explain your reasons why you are requesting and appeal:

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Provide or attach any additional information you would like us to review for this appeal.

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We must receive your grievance appeal within 60 days after you received the Notice of Grievance Determination. Mail or FAX this completed form to:

Fax number is 716-633-1153 Attention Member Services

Mailing address is: Member Services Department
Elderwood Health Plan
7 Limestone Drive
Williamsville, NY 14221

If you require any other assistance or if you have any questions, please call Member Services at 1-855-200-6247. For language assistance call 1-855-200-6247. For hearing or speech impaired call NY Relay dial 7-1-1.