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:

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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: 716-568-8378 Attention Member Services
Mailing address is: Member Services Department

Elderwood Health Plan
500 Seneca Street, Suite 100
Buffalo, NY 14204

If you require any other assistance or if you have any questions, please call Member Services at 1-866-843-7526. For language assistance call 1-866-843-7526. For hearing or speech impaired call NY Relay dial 7-1-1.