



ENROLLEE GRIEVANCE FORM

Date _____

Enrollee (Cardholder) Name _____

Dependent Name (If applicable) _____

Telephone _____

Enrollee Address _____

City, State, Zip _____

Enrollee Identification Number _____

Enrollee Group Name/Employer _____

Please be specific and check all areas that apply. Please state the nature of your complaint; give date(s), time(s), person(s), place(s), billed amount(s) etc. If any attempt was made to resolve the situation, please indicate details. You may attach an additional page if necessary.

- | | | |
|--------------------|---------------------|-----------------------|
| _____ physician | _____ service | _____ pharmacy |
| _____ office staff | _____ enrollment | _____ benefits |
| _____ hospital | _____ claim payment | _____ other (specify) |
| _____ eligibility | _____ medical care | |

Please describe your complaint/problem

Enrollee's Signature

Date

HealthLink Members Mail Complaint Form To:
HealthLink
P. O. Box 411424
St. Louis, MO 63141

Telephone: 1-800-624-2356 or (314) 925-6000
Facsimile: (314) 925-6637