Grievance Form

Subscriber Name: _____

Subscriber ID: _____

Date of Birth: _____

Contact Date: _____

Relationship to Subscriber: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Email Address: _____

Preferred Method of Communication: ❑ Mail ❑ Phone ❑ Email

Patient Name: _____

Date(s) of service (if applicable): _____

Claim Number (if applicable): _____

Medication Name (if applicable): _____

Provider Name (if applicable): _____

Billed amount (if applicable): _____

What is your grievance or complaint? (Please attach additional documents related to this complaint.)

_____

_____

_____

_____

What would you like us to do?

_____

_____

_____

_____

Name: _____

Signature: _____ Date: _____

Mail this form to:
MotivHealth Insurance Company
PO Box 709718
Sandy, UT 84070-9718

Or submit via email to:
correspondence@motivhealth.com