Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

GRIEVANCE REQUEST FORM

Received Date: / / mm, dd, yyyy

SECTION A: PERSONAL INFORMATION OF THE COMPLAINANT		
Name (Print):	Telephone number:	Contract number:
Address:	Date case filed:	Primary physician or provider number (if applicable):
Email:		
Grievance requested by: ☐ Member ☐ Legal guardian ☐ Provider ☐ Representative-relationship with member: _______________	PMG number:	Primary physician or provider phone number:

SECTION B:	**GRIEVANCE FILED AGAINST**	
Member 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.

12-20-038E

SECTION D: GRIEVANCE CLASSIFICATIONS (to be complete by PSM)

- ☐ 1. Plan or provider customer service
- ☐ 2. Plan or provider care management/case management
- ☐ 3. Access to care/services from plan or provider
- ☐ 4. Quality of Care
- ☐ 5. Plan Communications
- ☐ 6. Payment or billing issues
- ☐ 7. Suspected Fraud
- ☐ 8. Abuse/neglect/exploitation
- ☐ 9. Lack of timely plan response to a service authorization or appeal request
- ☐ 10. Plan denial of request for an expedited appeal
- ☐ 11. Other

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)

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

PLAN DE SALUD MENONITA
1-866-600-4753 (libre de cargos) 1-844-726-3345 TTY (audioimpedidos)
PO Box 364668, San Juan, PR 00936 · www.MenonitaVital.com

¿Ayuda con su Plan de Salud del Gobierno? ASES
Línea libre de cargos 1-800-981-2737
TTY 787-474-3389

- 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.

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, Aibonito, Cayey, Cidra, Coamo y Comerío. Please call our Service Line to know the location.

By email:
vitalgrievancesandappeals@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 a 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.

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 lingüística. 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.

Este 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).