Grievance, Appeal, Concern or Recommendation Form

If you wish to file a grievance, appeal, concern or recommendation, please complete this form. If you choose not to complete this form, you may write a letter that includes the information requested below. The completed form or your letter should be mailed to:

Sunshine Health
Appeal Department
P.O. Box 459087
Fort Lauderdale, FL 33345-9087
Phone 1-877-687-1169
TTY 1-877-941-9230
Fax 1-866-719-5373 (Appeals)
Fax 1-866-550-3248 (Grievance/Complaint)
FL State Relay: 1-800-955-8770

Member's Name:_____

Member's Ambetter #:_____

Street Address: _____

_____

City State Zip

Member Phone Number:_____

Tracking Number (if applicable; found in upper left hand corner of denial letter):

_____

Additional information to support the grievance, appeal, concern or recommendation (or attach):

_____

_____

_____

_____

_____

Member or Representative: _____

Daytime Phone #:_____ **Date:**_____

You must file an appeal within 180 calendar days of the date of the Notice of Action letter.
You must file a grievance within 365 calendar days of the date of the event.