Floridacare Health Plans, Inc., Grievance Form

Grievance Form

Date: _____
Name: _____
ID#: _____

Issue:

_____
_____
_____
_____
_____
_____

If the issue is a claims disagreement, did you pay for services?

_____
_____

If so, how much? _____

How would you want this issue resolved? _____

_____
_____
_____
_____
_____
_____

Please mail this form to the following address:

Floridacare Health Plans
6840 SW 40 Street Suite 201A
Miami, FL 33155.