# MEDICARE ADVANTAGE / MEDICARE PART D
# GRIEVANCE FORM

**Submit completed form to:**

Medicare Advantage/Medicare Part D
Appeals and Grievance B32AG
PO Box 1827
Medford OR 97501
**Email:** MedicareAppeals@regence.com
**Fax:** 1 (888) 309-8784

**Preferred correspondence method:**

☐ Mail
☐ Email _____

| | |
|---|---|
| Name | Telephone Number |
| ID Number | Provider Name |
| Date of Birth | Date of Issue/Service |
| Address | |

Please feel free to contact us if you need additional assistance in completing this form. Our office hours are 8:00 a.m. to 5:00 p.m. PT Monday through Friday. Our toll-free number is 1 (866) 749-0355 (TTY: 711).

**Please explain your reason for filing this grievance:** (attach additional sheets if necessary)

I hereby authorize my plan to obtain any medical records needed to answer my complaint. If applicable, this includes the release of information about alcohol or drug abuse, mental health, AIDS or HIV virus. This authorization begins on the date shown below and remains in effect so long as my request is being reviewed.

**Signature of Member or Authorized Representative***

**Today's Date**

*Please attach documentation demonstrating your authority to act on behalf of another. This may include a Power of Attorney or Appointment of Representative form (Form CMS-1696).