Grievance Request Form

For assistance with this form or questions regarding your grievance, please contact our Customer Service Department at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. PST.

Please mail or fax completed form to:

Fax: 1-866-339-8751

ATRIO Health Plans
Attn: Appeals and Grievances 2965
Ryan Drive SE
Salem OR 97301

Member Name:*		**ID #:***
Representation documentation for grievance requests made by someone other than enrollee: Attach documentation showing the authority to represent the enrollee (a completed Appointment of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact the plan. You can also contact 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TTD users can call 1-877-486-2048.		
Requestors Name (if other than member):		
Relationship to member:		
If representing the member, the below 3 lines of information should be your information.		
Address:*		
City:*	**State:***	**Zip:***
Telephone #:*		
Date of Incident:*		

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Please indicate the reason for the grievance (Is there additional information we should consider when reviewing this grievance?):*

Requestor's Signature:* **Date of Signature:*** **Time of Signature:***