REQUEST FOR REVIEW/GRIEVANCE FORM

Patient's Name: ____ DOB:_______________

Patient's S.S.#: ___________________________

Patient's Address: ____

Name of individual making this request and relationship to patient:

____

S.S.#: ___________________________ Daytime phone: ___________________

Please summarize your grievance and include the claim number shown on your Explanation of Benefits. Attach additional sheets as necessary. If possible, also attach a copy of any documents that relate to your grievance.

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Authorization for Release of Medical Records to Starmount

I authorize the release of my health or medical information and medical records regarding this request to Starmount for the purpose of conducting a review, limited as follows:

_______ No limitations

_______ Release only records for the time period of ________________ to _________________.

_______ Do not release the following information (dates of treatment, diagnosis, physician's name):

____

Signature of patient or representative: ___________________________________ Date: ______________

Authorization of Representative (if applicable)

I authorize ____ to represent me in this grievance and all related matters. I authorize the disclosure of my health information to my representative by Starmount during the process of Starmount's review of this grievance.

Authorized representative's daytime phone number: ________________________

Authorized representative's address: ____

Signature

Signature of patient or guardian: ____

Relationship to patient: ____ Date: _______________

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