GRIEVANCE/APPEAL & DISPUTE RESOLUTION FORM

COMPLAINT NUMBER:

INSTRUCTIONS: Fill out this form as completely as possible, including as much detail as you can and how you feel it could be resolved. If you need assistance completing this form, please call 517-780-3332 or 1-866-630-3690 or email customerservice@lifewayscmh.org for assistance. If you need in person assistance in Jackson or Hillsdale, please call or email to make an appointment.

APPEAL TYPE: ☐ **EXPEDITED**

- ☐ FAMILY SUPPORT SUBSIDY DENIAL
- ☐ SECOND OPINION OF INITIAL ACCESS DENIAL
- ☐ SECOND OPINION OF HOSPITALIZATION DENIAL
- ☐ NEGATIVE SERVICE DECISION
- ☐ CONTRACT/CREDENTIALING DISPUTE

GRIEVANCE TYPE:

- ☐ QUALITY OF TREATMENT
- ☐ QUALITY OF SERVICE
- ☐ AUTHORIZATION/HOSPITAL RECONSIDERATION

Did complainant try to resolve before filing grievance/appeal (i.e. speak to doctor, therapist, Team Supervisor, etc.)
☐ Yes ☐No ☐N/A

COMPLAINANT'S NAME:	**COMPLAINANT'S PHONE NUMBER:**
COMPLAINANT'S ADDRESS:	**NAME OF CONSUMER INVOLVED (if applicable):**

EXPLAIN/DESCRIBE THE GRIEVANCE/APPEAL/REQUEST (Additional space on back of form):

HOW DO YOU FEEL THIS COULD BE RESOLVED? _____

SIGNATURE OF PERSON COMPLETING FORM

DATE

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ADDITIONAL INFORMATION: