NON-DISCRIMINATION GRIEVANCE FORM

This form is available to you as a courtesy, and you are not required to complete it to submit a non-discrimination grievance. However, to begin the grievance process, we do need a written explanation of the problem. Please complete this form and return it to us.

By Email: G&A@AspirusHealthPlan.com

By Mail: Aspirus Health Plan
PO Box 1062
Minneapolis, MN 55440

YOUR INFORMATION

FULL NAME	LAST	FIRST	M.I.
ADDRESS	STREET ADDRESS		APARTMENT/UNIT
	CITY	STATE	ZIP CODE
HOME PHONE		**MEMBER NUMBER** *(If you have one)*	

DETAILS OF YOUR GRIEVANCE

Please describe the problem and explain why you believe discrimination was involved. If you are able, provide details such as dates, locations, requests you made, and who you talked to. You may add additional pages as needed. Once you return this form to us, we will contact you about your concerns. Thank you for your time and patience.

DETAILS

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