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:

EMAIL: G&A@aspirushealthplan.com **MAIL:** Aspirus Health Plan, PO Box 1890, Southampton, PA 18966

YOUR INFORMATION

First Name	Last Name	MI

Street Address	City	State	Zip Code

Phone Number *(include area code)*	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