



Member Appeal and Grievance Form

To request an appeal of an adverse organization determination on your Medicare Part C medical care, in whole or in part, please complete the information below and attach any documentation you feel would support your appeal.

To file a grievance, please complete the information below and attach any documentation you feel would support your grievance. A grievance is any complaint or dispute expressing dissatisfaction with the plan or one of our network providers or pharmacies, including a complaint about the quality of your care. If your problem relates to a coverage determination, please refer to your Evidence of Coverage, Chapter 9, Section 6.

Your appeal or grievance must be filed within 60 days of the initial determination or the date of the event. This form, along with any documentation to support your appeal or grievance, can be mailed or faxed to:

Vibra Health Plan
ATTN: Appeals & Grievances
PO Box 60250
Harrisburg, PA 17106-0250
Fax: 1-844-774-5585

Appeal or grievance requests, including expedited requests or a pre-service appeal, can be made by calling Member Services at 1-844-388-8268 (TTY users call: 711) OR via fax to 1-844-774-5585.

Member Information

Member Name:		Date of Birth:
Address:		
City:	State:	Zip:
Member ID Number:	Primary Telephone:	

Item or Service you are Appealing or Grieving

Date the Item or Service was Received:	Claim Number (if applicable):	
Item or Service:		
Provider:		
City:	State:	Zip:
Authorization Number (if applicable):		

Reason for Appeal or Grievance

Please explain your appeal or grievance and your expected resolution:

If you wish to be represented by another person for your appeal or grievance, you will need to submit an Appointment of Representative (1696) Form, which will serve to name an individual to advocate on your behalf. You may contact Member Services at 1-844-388-8628 to request an Appointment of Representative Form, or visit our website at www.vibrahealthplan.com

Member or Authorized Representative Signature:	Date:
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Important Information about your Rights

For more detailed information about your Appeal and Grievance Rights, please reference your Evidence of Coverage.

If you have any question or require further assistance regarding this matter, please call our Member Services Department at 1-844-388-8268 (TTY users call: 711), 8 a.m. and 8 p.m., 7 days a week.

Vibra Health Plan is a PPO with a Medicare contract. Enrollment in Vibra Health Plan depends on contract renewal.



NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Vibra Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Vibra Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Vibra Health Plan provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats)
- ✓ Qualified interpreters, and information written in other languages

If you need these services, call 1-844-388-8268 (TTY: 711).

If you believe that Vibra Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person; or you can file a grievance by mail, phone, fax, or email at:

Vibra Health Plan

P.O. Box 60250 Harrisburg, PA 17106-0250
1-717-510-6203 (TTY: 711), fax, 1-844-744-5585
CRC@vibrahealthplan.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

To talk to an interpreter in your language at no cost, call 1-844-388-8268 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 1-844-388-8268 (TTY: 711).

欲免費用本國語言洽詢傳譯員 · 請撥電話 1-844-388-8268 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 1-844-388-8268 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 1-844-388-8268 (TTY: 711).

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무료 전화 통역 서비스 1-844-388-8268 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 1-844-388-8268 (TTY: 711).

للتحدث مجاناً إلى مترجم للغتك، يرجى الاتصال بـ 1-844-388-8268 (الهاتف النصي: 711)

Pour parler à un interprète dans votre langue sans charges, téléphoner à 1-844-388-8268 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-388-8268 an (TTY: 711).

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Aby porozmawiac z tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 1-844-388-8268 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 1-844-388-8268 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 1-844-388-8268 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 1-844-388-8268 (TTY: 711).