

**SHP Member Services**

4944 Parkway Plaza Blvd, Suite 110  
Charlotte, NC 28217



**MEMBER COMPLAINT/GRIEVANCE APPEAL FORM**

**Member Information:**

Name of Member involved in Complaint: \_\_\_\_\_ CIN #: \_\_\_\_\_

Head of Household/Guardian: \_\_\_\_\_ File #: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Explanation of Incident/Complaint:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reason(s) for Complaint Appeal:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How would you like your complaint appeal resolved/determined:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Complainant or Designee: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this form to:**      **Suffolk Health Plan**  
4944 Parkway Plaza Blvd, Suite 110  
Charlotte, NC 28217  
**Attn: Member Services Center or fax to 800-334-4195**

You have no less than sixty (60) business days from the date you received the resolution letter to file an appeal. For assistance in completing this form, please call our Member Services Department at 1-877-747-6789.

**For Official Use Only — Please do not write below this line**

Receipt of the Complaint Appeal (Date): \_\_\_\_\_ Received by: \_\_\_\_\_

Clinical Complaint:      No      Yes      If yes, refer to: \_\_\_\_\_ Date referred: \_\_\_\_\_

Reviewed and approved by (Signature): \_\_\_\_\_ Date: \_\_\_\_\_