Minuteman Health™

Complaint/Appeal Request Form

Requester Name: __________________ Daytime Phone Number:________________

Member Name: ___________________ MHI Identification Number: _____________

Address: *Date(s) of Service:

_________________________________ ______________________________________

_________________________________ ______________________________________

**Please note that appeal requests must be received by MHI within 180 calendar days of the adverse determination.*

Please provide a written description of your complaint. Please include names and dates whenever possible. If necessary you may attach a separate sheet to this form.

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Please also provide the resolution that you are looking for.

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Signature of Member
or Authorized Representative**:_______________________ Date:________________

***Please make sure a signed Authorization of Personal Representative Form is on file.*

Completed forms may be mailed to the address below or faxed to 888-225-8716

Minuteman Health
Attention: Complaints & Appeals
PO Box 120025
Boston, MA 02111