

MyTruAdvantage

MyTruAdvantage Grievance Form

A grievance is a complaint about MyTruAdvantage, one of our network providers or pharmacies, or the quality of care you received. Grievances do not include complaints about whether a service or drug is covered, or how much you must pay — those are called appeals, and they follow a different process. If you want to dispute a coverage or payment decision, call us at the number below and we will help you get started with an appeal instead.

You may file a grievance within 60 days of the date the event happened.

How to Submit This Form

Mail:

MyTruAdvantage, P.O. Box 428, Columbus, IN 47202-0428

Fax:

1-812-378-7048

Phone:

1-844-425-4280 (TTY: 711)

Hours: October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. April 1 – September 30, 8:00 a.m. – 8:00 p.m. local time, Monday – Friday. On weekends and holidays outside these hours, please leave a message and we will return your call.

Filing on Behalf of the Enrollee

You may have someone else — such as a family member or friend — file this grievance for you. That person must be appointed as your representative. Call the number above, or visit www.mytruadvantage.com, to learn how to name a representative.

If someone other than the enrollee is filing this grievance, please attach a completed Authorization of Representation Form (CMS-1696) or other written proof of representation. For help appointing a representative, contact us or call 1-800-MEDICARE, 24 hours a day, 7 days a week.

Section 1 — Enrollee Information

Enrollee's name	Date of birth	
Enrollee's address		
City	State	ZIP code
Phone	Plan ID number	

Section 2 — Requestor Information

Complete this section only if you are filing this grievance on behalf of the enrollee.

Requestor's name	Relationship to enrollee	
Requestor's address		
City	State	ZIP code
Requestor's phone		

Section 3 — What Is Your Grievance About?

Check the option that best describes your concern.

- ☐ Quality of care or services
- ☐ Customer service, or how you were treated by plan staff
- ☐ Access to care (for example, appointment wait times or difficulty reaching us)
- ☐ Pharmacy service
- ☐ Plan communications or marketing
- ☐ Other

Section 4 — Requesting a Fast (Expedited) Review

The two options below are only for complaints about how quickly we handled a request — not for disagreeing with the coverage or payment decision itself. If you want to dispute a coverage or payment decision, contact us for help starting an appeal instead of using this section.

- ☐ We refused your request to speed up (expedite) a coverage decision, appeal, or redetermination, and you disagree with that refusal.
- ☐ We took additional time (up to 14 more days) to decide your coverage request, grievance, or appeal, and you disagree with that delay.

If you checked either box above, we will complete our review within 24 hours.

Section 5 — Describe Your Grievance

Please describe what happened, including relevant dates, names, and locations. Attach additional pages if you need more space.

Signature of person filing this grievance (enrollee or enrollee's representative)	Date
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