MyTruAdvantage Grievance Form

A grievance is a type of complaint you make about us or one of our network providers or pharmacies or the quality of your care. This type of complaint does not involve coverage or payment determinations. You may file a written grievance within 60 days after the date the grievance event occurred.

This grievance form may be sent to us by mail or fax:

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

Fax: 1-812-378-7048

You may also submit a complaint by contacting us by phone:

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

We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m., local time, 7 days a week. From April 1 through September 30 from 8:00 a.m. to 8:00 p.m., local time, Monday through Friday; on weekends and holidays, you will need to leave a message.

Who may file a grievance: If you want another individual (such as a family member or friend) to file a grievance for you, that individual must be your representative. Contact us by calling the phone number above or through our website at *www.mytruadvantage.com* for information on how to name a representative.

Enrollee's Information

Enrollee's name	Date of birth	
Enrollee's address		
City	State	Zip
Phone	Enrollee's plan ID number	

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's name	Requestor's relationship to enrollee	
Address:		
City	State	Zip
Phone		

Representation documentation for grievances made by someone other than enrollee: Attach documentation showing the authority to represent the enrollee (a complete Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-MEDICARE, 24 hours/7 days a week.

Type of grievance

Please choose one: ☐ Medical benefits ☐ Pharmacy benefits ☐ Other
<u>Important note – Expedited Decisions:</u> If you would like to file an expedited grievance, please select one of the following options: ☐ Check here if you are dissatisfied with our decision and want a 24-hour review of our refusal to provide you with a fast coverage determination (pharmacy benefit), organization determination (medical benefit), redetermination or appeal review. ☐ Check here if you are dissatisfied with our decision and want a 24-hour review of our taking a 14-day extension to review your grievance, organization determination, or appeal.

Please describe your grievance. Attach any additional information about your grievance.

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