*Customer Services*
Report of Grievance or Appeal

**INSTRUCTIONS**: Please provide the information requested below to initiate your complaint. You can attach any additional pages you feel are necessary**.**

**For Standard Appeals**: We will not be able to process your appeal if a written/signed request is not received within 30 days of your verbal request. We will not be able to continue benefits during an appeal until a written/signed request is received. Please submit this form or send us an e-mail including this information to confirm your appeal in writing.

Send completed form to: Woodlands Behavioral Healthcare Network
Customer Services
960 M-60 East State Street
Cassopolis, MI 49031 Or fax to: 269.445.3216
Or e-mail to: reginaw@woodlandsbhn.org

| | |
|---|---|
| Customer Name: | |
| Customer phone number: | |
| Customer address: | |
| Date of complaint: | |
| Customer Signature: | |

My Grievance or Appeal is about:

| Provider/Agency/Staff Name | Service (s) |
|---|---|
| | |
| | |

Please describe why you are filing this complaint:

| |
|---|
| |

What is your desired solution:

| |
|---|
| |

Date Received by Customer Services: _____ Customer ID#: _____

| **Authorized Representative**<br>For an Appeal or Grievance, you can name someone to act for you.<br>If you would like to name a person/agency to act for you, please complete this page.<br>If you will complete the grievance or appeal on your own, you can leave this blank. | |
|---|---|
| Representative Name (please print): | |
| Relationship to Customer: | |
| Representative phone: | |
| Representative address: | |

**For the Customer:**

- By signing below, you agree that the named person/agency above will act on your behalf for the grievance or appeal stated on this form.
- By signing below, you authorize (Woodlands Behavioral Healthcare Network) to disclose your personal information to the authorized representative.
    - We will only release information that relates to the stated grievance or appeal.
    - If the Authorized Representative asks for information not related to the grievance or appeal, we will tell them that we need a full Release of Information (MDHHS-5515) signed by you.
- By signing below, you agree that the named authorized representative will receive any mail or calls related to your grievance or appeal instead of you.
- By signing below, you agree that when the grievance or appeal is resolved, they will no longer be your representative.
    - If you file a new grievance or appeal, you would need to complete this form again to name a representative.

Customer Signature: _____ Date:_____

**For the Representative:**

- By signing below, you agree to act on behalf of the named customer for the stated grievance or appeal.
- By signing below, you agree to receive personal information of the customer related to the grievance or appeal.
    - If you ask for information not related to the grievance or appeal, we will tell you that we need a full Release of Information (MDHHS-5515) signed by the customer.
- By signing below, you agree to receive any mail or calls related to the grievance or appeal instead of the customer.
- By signing below you agree that when the grievance or appeal is resolved, you will no longer be the customer's representative.
    - If they file a new grievance or appeal and want you to represent them, we would need this form filled out again.

Representative Signature: _____ Date:_____