

WRITTEN CONSENT TO GRIEVANCE FORM

For grievances filed by a provider on behalf of a member, the health plan must obtain at least verbal consent from the member to allow the provider to file on their behalf. Member can provide written consent as well, if preferred. Please complete this form and return to CenCal Health.

Member Name	
Member ID#	
Member's Date of Birth	
Provider Requesting Grievance	
Description of Grievance	
Date of Service(s) / Incident	

I, _____, give my consent to allow CenCal Health to process the grievance submitted by my provider, _____. Please discuss any aspects concerning this grievance with my provider, which may include disclosing confidential medical information, as needed.

Signature: _____ **Date:** _____
(Member / Authorized Representative)

Please fax this form to CenCal Health at: 805-692-1684 or

Mail form to:
CenCal Health
Attention: Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110