Indiana Farm Bureau Health Plans

Grievance

I wish to submit the following Grievance in accordance with the Indiana Farm Bureau Health Plans Grievance procedure:

- □ **Reconsideration – Attn: Indiana Farm Bureau Health Plans Member Grievance Department**
  This option should be used if you would like to request an informal review of an adverse benefit determination, answer questions, or resolve a potential dispute.

- □ **Level 1 – Grievance – Attn: Indiana Farm Bureau Health Plans Member Grievance Department**
  This option should be used if this is your first formal request for a review of an adverse benefit determination.

- □ **Level 2 – Grievance – Attn: Indiana Farm Bureau Health Plans Member Grievance Department**
  This option should be used if this is your second request for a review of an adverse benefit determination. This request will be forwarded to Indiana Farm Bureau Health Plans for review and final determination.

Member Name:
Member ID Number:
Provider Name (if applicable):
Date of Service in question (if applicable):
Claim number (if applicable):

When submitting your Grievance, please provide a detailed explanation. You may use the back of this form if necessary. It is your responsibility to (1) include any relevant information in your explanation and (2) attach pertinent documents including, but not limited to, prior correspondence, medical records, references from your Contract, and any other information you would like considered.

Please send this form along with the information requested above to:

Indiana Farm Bureau Health Plans
Attention: Appeals/Grievances
PO Box 313
Columbia, TN 38402-0313

Explanation of Grievance:

I do hereby authorize any physician, nurse, hospital, or provider of medical service to furnish Indiana Farm Bureau Health Plans and/or UMR (third party administrator) any and all medical, admission and insurance records pertaining to me or the member referenced above. I certify this information is accurate and complete.

Member Signature _____ Date _____