

Prior Authorization Denial Grievance Document

Member Name: _____

Member ID: _____

Date of Birth: _____

Phone Number: _____

Provider Name: _____

Provider Phone: _____

Provider Fax: _____

Authorization Number: _____

Service Requested: _____

Date of Denial: _____

Reason for Grievance

Supporting Documentation List

Member or Provider Statement

Signature: _____ **Date:** _____

Printed Name: _____ **Role:** _____