MCS Classicare (HMO)

MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
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MCS CLASSICARE GRIEVANCE SUBMISSION FORM

Referral Source

☐ Call Center	☐ Service Center	☐ Mail	☐ e-mail	☐ Ethics Point	☐ Fax	☐ Phone Call (Not received through the Call Center)	☐ OPP/SHIP	☐ Referred by Compliance	☐ Other (Please specify):

Reserved for the referring Unit/ Department Please stamp the designated area with the date and time	Name of the employee who is referring the case Position of the employee who is referring the case Signature of the employee who is referring the case	Reserved for Grievances and Appeals Please stamp the designated area with the date and time

ENROLLEE INFORMATION

First Last Name	Second Last Name	Name & Initial	Contract Number	Phone Number	Filing Date

Postal Address					
Urbanization / Ward	Street	Number or P.O.Box	City	State	Zip Code

INFORMATION OF THE PROVIDER AGAINST WHOM THE COMPLAINT IS FILED

Name of the person against whom the grievance is filed	Position	Name of the Office or Institution	National Provider Identifier

DESCRIPTION OF THE FACTS

Indicate how the events you allege occurred

CERTIFICATION

I CERTIFY THAT THIS DOCUMENT IS MY GRIEVANCE AND IT CONTAINS, IN MY OWN WORDS, THE TRUTH ABOUT EVENTS THAT OCURRED. I FURTHER CERTIFY THAT I HAVE BEEN NOTIFIED ABOUT FRAUD WITHIN THE GRIEVANCE FILING PROCESS.

Signature of enrollee or legal representative