



# Grievance and Appeal Form

This form is for your use in filing an appeal or grievance pertaining to any part of the care or service you received from First Coast Advantage. We take your concerns seriously and we will respond in a timely manner. If you have any questions, contact our Member Services department at 1-866-270-2422, 8 a.m. to 7 p.m. Monday through Friday.

Print or type the following information:

\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Medicaid ID# Date of Birth  M  F  
(Male/Female)

\_\_\_\_\_  
Member Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State Zip Telephone

**Complete this section if someone other than the member files the complaint.**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Relationship to Member \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

State the reason for your appeal or grievance, with dates, times, persons, location, etc. involved. Also send copies of any other information that may be related to your appeal or grievance.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please sign below and mail this form to:

**FIRST COAST ADVANTAGE**  
Attn: Member Appeals and Grievances  
580 W. 8<sup>th</sup> St., T-20  
Jacksonville, FL 32209

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you require a translation service to assist you with this form, please contact our Member Services department at 1-866-270-2422.