CONSENT FOR PROVIDER TO FILE A GRIEVANCE FOR MEMBER

Provider Name	**Provider Plan ID Number**
Provider Address	
Description of Specific Service or Item for which I agree the Provider Can File a Grievance	**Name and Address of Health Partners Where Grievance Will Be Filed**

Name of Member	**Member's Date of Birth**
Member ID No.	
Member Mailing Address	
Member Daytime Telephone Number	**Member Evening Telephone Number**

I, **[Name of Member]**, agree that **[Name of Provider]** can file a Grievance for me with Health Partners about the service or item described above.

By signing this consent form, I understand the following:

1. I or my representative may not file a Grievance about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the Grievance process by telling Health Partners and **[Name of Provider]** in writing that I do not want **[Name of Provider]** to continue the Grievance process for me.
2. My consent to have the Provider file the Grievance for me will automatically no longer be in effect if the Provider does not file a Grievance or does not continue with the Grievance through the end of the Grievance review process.

3. I or my representative has read, or has been read, this consent form, and have had it explained to me until I understand it. I or my representative understands the information in this consent form.

_____ _____

Signature of Member or Representative **Date**

_____ _____

Witness Signature **Date**

_____

Print Witness Name

If the Member is unable to sign this Consent Form because the Member is legally incompetent:

_____

Name of Person Signing on Behalf of Member

_____

Address of Person Signing on Behalf of Member

_____

Relationship of Person Signing to Member

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