Grievance Form

Please send to:
America's 1st Choice Health Plans, Inc.
Risk Management Dept.
P.O. Box 210769
Columbia, SC 29221-0769
Fax: 803-748-4533
Phone: 803-748-4534

Member's Name:		
Member I.D.#:		
Address:		
City:	State:	Zip:
Are You:	___The member filing the grievance	
	___Legal representative (include documentation)	
	___Other	
Physician involved (if applicable):		
Facility involved (if applicable):		

State your grievance & any other contact made with America's 1st Choice regarding this grievance (Please be as specific as possible. You may use the back of this form for additional space):
What would you like to happen?

Attach any supporting documentation (i.e. invoices and payments, signed documentation from physicians and/or other providers, etc.).

_____ _____
Member Signature Signature Date