|  |
| --- |
| **INSTRUCTIONS**: Please provide the information requested below to initiate your complaint. You can attach any additional pages you feel are necessary**.****For Standard Appeals**: We will not be able to process your appeal if a written/signed request is not received within 30 days of your verbal request. We will not be able to continue benefits during an appeal until a written/signed request is received. Please submit this form or send us an e-mail including this information to confirm your appeal in writing.  Send completed form to: Customer Services 5250 Lovers Lane, Suite 200 Portage, MI 49002 Or fax to: 1-269-441-1234 Or e-mail to: info@swmbh.org |
| Customer Name: |  |
| Customer phone number: |  |
| Customer address:  |  |
| Date of complaint: |  |
| Customer Signature: |  |

My Grievance or Appeal is about:

|  |  |
| --- | --- |
| Provider/Agency | Service |
|  |  |
|  |  |

Please describe why you are filing this complaint:

|  |
| --- |
|  |

What is your desired solution:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **Do you want to give someone permission to act on your behalf?**If yes, then we need the section below to be completed. | [ ] Yes [ ] No |
| Representative Name (please print): |  |
| Customer Signature: |  |
| Representative Signature: |  |
| Representative phone: |  |
| Representative address: |  |

Date Received by Customer Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Customer ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_