



REQUEST FOR REVIEW/GRIEVANCE FORM

Patient's Name: _____ DOB: _____

Patient's S.S.#: _____

Patient's Address: _____

Name of individual making this request and relationship to patient: _____

S.S.#: _____ Daytime phone: _____

Please summarize your grievance and include the claim number shown on your Explanation of Benefits. Attach additional sheets as necessary. If possible, also attach a copy of any documents that relate to your grievance.

Authorization for Release of Medical Records to Starmount

I authorize the release of my health or medical information and medical records regarding this request to Starmount for the purpose of conducting a review, limited as follows:

- _____ No limitations
- _____ Release only records for the time period of _____ to _____.
- _____ Do not release the following information (dates of treatment, diagnosis, physician's name):

Signature of patient or representative: _____ Date: _____

Authorization of Representative (if applicable)

I authorize _____ to represent me in this grievance and all related matters. I authorize the disclosure of my health information to my representative by Starmount during the process of Starmount's review of this grievance.

Authorized representative's daytime phone number: _____

Authorized representative's address: _____

Signature

Signature of patient or guardian: _____

Relationship to patient: _____ Date: _____