Internal Grievance Authorized Representative Form

1.	Call 866-606-3700, Monday through Friday, 7 a.m. to 5:30 p.m. to speak with one of our representatives. We can answer any questions you may have.
2.	If you or someone acting on your behalf wishes to file a grievance, please complete this form and mail to: MeridianHealth Attn: Grievance and Appeals Dept. PO Box 44287 Detroit, MI 48244
3.	MeridianHealth will mail you the final grievance resolution within 90 days.

Please print the following info:

Member Name (Last, First, Middle initial)	**Male/Female**	**Date of Birth**
Address	**City, State, Zip**	
Phone Number	**Medicaid ID #**	

Date:_____ **Member's Signature**:_____

Authorized Representative: You may authorize in writing any person such as your doctor, lawyer, friend, parent or spouse to represent you in the internal grievance/appeal process. Complete the info below to authorize a representative other than yourself.

Name	**Phone Number**
Relationship to Member	
Address	**City, State, Zip**

Authorized Representative Signature:_____

Please turn over to complete form.

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Please write about your grievance with as much detail as possible. Attach extra pages if needed.