HealthPlus
2050 South Linden Road, Flint, MI 48532

HEALTHPLUS MEMBER GRIEVANCE APPEAL FORM

MEMBER NAME _____ **SUBSCRIBER NUMBER** _____

We are sorry you are having difficulty with your HealthPlus of Michigan coverage. Please document in detail the problem you are experiencing. Remember to sign your grievance appeal at the bottom. Include any additional documentation such as bills, referral letters, etc., and return in the enclosed pre-addressed stamped envelope. Thank you.

Member Signature _____

Additional space provided on the back