Grievance Form

Member's name _____ Doctor_____

Address _____ Phone _____

NHP member ID number _____

SUMMARY OF GRIEVANCE

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Have you contacted Neighborhood Health Partnership regarding this matter? _____

If yes, what was the result of this contact? _____

_____

_____

_____

What can we do to help solve your problem? _____

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Please mail this form to: Neighborhood Health Partnership, PO Box 025680, Miami, FL 33102-5680

Member's signature _____ Date_____

Neighborhood Health Partnership
A UnitedHealthcare Company