

MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429 e-mail:coordinadordequerellas@medicalcardsystem

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MCS CLASSICARE GRIEVANCE SUBMISSION FORM

П	Referral Source												
	Call Center	Service Center	Mail	e-mail	Ethics Point	Fax	Phone Call (N received through the Call Center)	OPP/S	HIP	Referred by Compliance	J	Other (Please specify):	
	Reserved for the referring Unit/ Department Please stamp the designated area with the date and time			ne	Name of the employee who is referring the case Position of the employee who is referring the case Signature of the employee who is referring the case				Reserved for Grievances and Appeals Please stamp the designated area with the date and time				
ENROLLEE INFORMATION													
	First Last Name Second Last Name				Name & Initial		Contract Number			Phone Number		Filing Date	
Urbar	nization / Ward			Street		Postal Address	Num	ber or P.O.Box	City		State	zip Code	
INFORMATION OF THE PROVIDER AGAINST WHOM THE COMPLAINT IS FILED													
	Name of the person against whom the grievance is filed				Position		Name of the Office or Institution			National Provider Identifier		Provider Identifier	
						DESCRIPTION OF T	HE FACTS						
Indicate how the events you allege occurred													
CERTIFICATION													
I CERTIFY THAT THIS DOCUMENT IS MY GRIEVANCE AND IT CONTAINS, IN MY OWN WORDS, THE TRUTH ABOUT EVENTS THAT OCURRED. I FURTHER CERTIFY THAT I HAVE BEEN NOTIFIED ABOUT FRAUD WITHIN THE GRIEVANCE FILING PROCESS.													
	MCS Classicara is an HMO plan subscribed by MCS Advantage. Inc. Confidentiality Notices. This communication is privileged and confidential, and/or protected health												
	Signature	of enrollee or lega	l representative	IVICS Class	sicule is all trivio piant suc	Sociaca by Ivica Auve	intage, inc. confidentia		uincatio	in is privileged and collin	aciitiai, c	ana, or protected nearth	

immediately and arrange for its return.

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