BlueChoice® HealthPlan of South Carolina

Medicaid

Member Grievance Form

Instructions: Please complete this form and attach any related documents.

Mail to: **Attn: Grievance Department**
BlueChoice HealthPlan of South Carolina
P.O. Box 100148
Columbia, South Carolina 29202-3148

Fax to: **1-866-387-2968**

You may also file by phone. Just call the phone number on your member ID card.

Date: _____

Member Name: _____ Member ID No./ CIN No.: _____

Address: _____

Phone No.: _____

Information about the Grievance

This information becomes part of the permanent record. Please write clearly. Use extra paper if needed.

Date of Incident: _____

Describe what happened (use extra paper if needed):

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X _____ _____
Signature Date

If you need assistance with this form, please call the phone number on your BlueChoice HealthPlan identification card.

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