Oscar Grievance Form - Florida

Completion of this form is optional. However, we encourage the form's return to assist in resolving your grievance. To file a grievance, you or your authorized representative may contact our Member Services Department using the telephone number displayed on the member ID card or submit a letter in writing to the address listed below. Oscar will mail a written response within 30 calendar days from the date of receipt.

1. Member Information

Member Name: _____ Member ID #: OSC_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Date of Birth _____

2. Complainant Information (if different from Member)

*If you are **not** the Member, please provide **your** information here.*

Your Name: _____

Company: _____

Relationship to Member:

❏ Parent ❏ Spouse ❏ Other: _____

Your Mailing Address: _____

City: _____ State: _____ Zip: _____

Your Phone Number: _____ Your Fax Number: _____

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3. Please describe the nature of your grievance below (please use additional pages if necessary). Add any facts your feel should be considered in the review of your grievance. As a reminder, please attach any supporting documentation you have.

If your grievance involves a claim, please additionally provide the following (if available):

Claim ID(s): _____ Date(s) of Service: _____

Provider(s) and/or Facility Name(s): _____

4. Did you speak with an Oscar representative about this issue?

___NO ___YES - If yes, please provide the name of the individual that you spoke to and the date:

Name of Rep(s): _____ Date(s): _____

If no, you may be able to resolve your issue immediately by contacting Oscar at 1-855-672-2755 or help@hioscar.com.

5. Authorization (if submitted by someone other than the Member)

Please note that Oscar is unable to share a Member's Personal Health Information (PHI) without the express written permission of the Member via a HIPAA authorization form. Please contact Oscar or visit hioscar.com/forms to get a copy of the HIPAA authorization form, which must be completed and signed by the Member.

Has the Member(s) signed a HIPAA authorization form authorizing you to speak on the Member's behalf?

___ NO ___YES

If we do not have a HIPAA authorization on file, the written response for a grievance filed by a non-authorized party will be mailed to the Member.

Would you like us to send the response to you instead? ___ NO ___YES

If YES, Oscar will contact the Member to request they authorize you to receive this information.

6. Signature and Submission

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this grievance. My failure to do so may result in Oscar closing the investigation related to this matter.

Signature _____ Date _____

Name (Printed): _____

Please submit this completed form (Attn: Grievances) to one of the following:

By mail:
Oscar Insurance Company of Florida
Attn: Grievances
P.O. Box 52146
Phoenix AZ, 85072

By email:
help@hioscar.com
Attn: Grievances

By fax:
888-977-2062
Attn: Grievances