Oscar Grievance Form - New York

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

If you are filling this form out on behalf of multiple Members, please indicate that below and include a separate page with all of the requested information for each additional Member. If you are filling this form out on behalf of all Members in a Group, please indicate that below and be sure to include the Group ID #.

Member Name: ____________________________________________________________

Member ID #: OSC____________________________ Group ID # (if applicable): BIZ____________________________

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
- ☐ HR Administrator
- ☐ Broker
- ☐ Other: ___________________________________________________________________________________________

Your Mailing Address: __________________________________________________________________________________

City: _____________________________________________________ State: _______________ Zip: _______________

Your Phone Number: ____________________________ Your Fax Number: ______________________________

PO Box 52146, Phoenix AZ, 85072
3. Please describe the nature of your grievance below (please use additional pages if necessary). Add any facts you 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 Corporation
Attn: Grievances
P.O. Box 52146
Phoenix AZ, 85072

By email:
help@hioscar.com
Attn: Grievances

By fax:
888-977-2062
Attn: Grievances