

Grievance Submission Form

Please fill out the following information to submit a grievance to the NYC Employees PPO (NYCE PPO) plan. If you wish to express dissatisfaction regarding a claim decision, please submit a Post-Service Appeal Request form. If you are filing this grievance on behalf of someone else, please also include the Designation of Authorized Representative form with this request.

Request information

Today's date / /
MM DD YYYY

Patient name _____ Patient date of birth / /
MM DD YYYY

Member ID _____ Member name _____

Please select your grievance type. If your complaint does not fall under one of these categories, please submit a NYCE PPO Post-Service Appeal form to ensure proper handling.

Services not rendered

Quality of care/service

Fraud/waste/abuse

Incorrect billing/charges

Quality of member services

Health plan/benefits

Other _____

Are you including medical records or other documents with your grievance? Yes No

Please note: If no documentation is submitted, our review will be based on the information we currently have on file.

Name, address and phone number of person filling out the form for NYCE PPO to contact with any questions.

Name _____

Address _____ City _____ State _____ ZIP _____

Phone number _____ - _____ - _____

Description of grievance _____

Please mail your completed form along with any supporting medical documentation to:

NYCE PPO Grievance, P.O. Box 21534, Eagan, MN 55121