Evry Health
A Globe Life Company

For Questions Please Call: 855-579-3879

MEMBER COMPLAINT FORM

If you would like to file a formal complaint regarding the care or service you have received from Evry Health or any of our participating providers, please complete this form. The information received will assist our Complaint Department to begin the investigation process for your concern. You have the right to file a complaint or a complaint appeal against EVRY Health or its providers without fear of negative action by EVRY Health or your providers.

A "Complaint" is defined as a written communication primarily expressing a grievance against an insurance company or agent, per TDI Home Insurance Glossary. A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination.

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

Fax to: 972-807-0596
Email: support@evryhealth.com
Mail to: PO Box 571208, Dallas, TX 75357

Your complaint must be filed within 90 days (three months) from the date of occurrence. If you are not satisfied with the decision, you have to file an appeal within 30 days (one month).

Member Information

<table>
<tr><td>Member's First Name:</td><td>Member's Last Name:</td><td>Member's Birthdate (MM/DD/YYYY)</td></tr>
<tr><td colspan="2">Member's Address:</td><td>Telephone Number:</td></tr>
<tr><td colspan="2" rowspan="2">Employer Plan Type
Circle one:
EPO
EPO HDHP
PPO
PPO HDHP</td><td>Email Address:

Communication by email is OK: ☐</td></tr>
<tr><td>Member ID:</td></tr>
</table>

PERSON FILING THE COMPLAINT (You have the right to appoint someone to file your complaint or represent you during the process. If the member is a minor or an adult who is incapacitated, a parent, guardian, conservator, or relative can file the complaint)

Name: _____
Relationship: ☐ Mother ☐ Father ☐Grandparent ☐Guardian ☐Other_____

If you have given Evry Health Plan appropriate consent for an Individual to act on your behalf, Evry Health Plans will send response acknowledgement/appeal or complaint correspondence to that individual.

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Description of the concern or issue

Date of occurrence:	Who is this complaint against?
Please describe the nature of your complaint or complaint appeal below (please use additional pages if necessary and attach supporting documents). Add any facts you feel should be considered in the review of your complaint or complaint appeal:	

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 complaint. My failure to do so may result in closing the investigation related to this matter.

_____ _____

Member's Signature
(Parent or guardian if the member is a minor)

Date

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If you are the treating provider submitting this request on behalf of a member, you must submit an Appointment of Representative form signed by you and the member, and an Authorization to Release Health Care Information form signed by the member.

A member may not appeal on behalf of a provider, if the denial document states the payment is the provider's responsibility. The provider must submit a reconsideration request (in writing) to Evry Health.

If you are submitting this request on behalf of the member, you must complete and return to Evry Health a copy of the following forms (see www.evryhealth.com for forms):

1. HIPAA Authorization
2. Authorized Representative

If the member is unable to sign the Authorized Representative form, then you must sent Evry Health a Health Care and/ or Financial Dependent Power of Attorney form stipulating you are currently authorized to represent the member.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you are not the intended recipient, any use, distribution, or copy is strictly prohibited. If you have received this facisimile in error, please notify us immediately and destroy this document.