Please note that complaints (grievances & appeals) must be received by Health New England within 60 days of the adverse determination or from the date of the incident. Complaints received after this timeframe cannot be accepted.

Please provide a written description of your complaint. Please include names and dates whenever possible. If necessary, you may attach a separate sheet to this form.

Please provide the resolution that you are looking for.

Signature of Member or Authorized Representative: __________________________  Date: __________________________

If you are acting as a Personal Representative to file a grievance or an appeal on someone else’s behalf, an Authorization of Personal Representative Form (found at healthnewengland.org/forms) MUST be completed. Authorization to file a grievance or an appeal on someone else’s behalf is only valid for ONE YEAR from the date the Authorization Form is signed.

Completed forms may be mailed to the address below or faxed to (413) 233-2685:

Health New England
Attention: Medicare Advantage Complaints & Appeals
One Monarch Place, Suite 1500
Springfield, MA  01144-1500