UNICARE
An Anthem Company

Instructions: Please complete this form and attach any related documentation.

Mail to: **Attn: Grievance and Appeals Department**
UniCare Health Plan of West Virginia, Inc.
P.O. Box 51
Charleston, WV 25321-0051

You may also file by phone. Just call the phone number on your UniCare member ID card.

Date: _____
Member name: _____ Member ID No./CIN No.: _____
Address: _____
Phone No: _____

Information about the Grievance

This information becomes part of the permanent record. Please write clearly. Use extra paper if needed.

Date of
Incident: _____

Describe what happened (use extra paper if needed):

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Signature of member (parent or guardian if member is a minor):

X_____ **Date:** _____

If you need assistance with this form, please call the phone number on your identification card.