HEALTH REPUBLIC
INSURANCE OF NEW YORK

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315-433-5445 Fax

Claim Grievance Form

Section 1. (Required). Enrollee Information.

Enrollee Name (primary person enrolled in HRI plan):	Patient Name (if different from enrollee name):
Member ID# (located on HRI member ID card):	Plan ID# (located on HRI member ID card):

Section 2. Claim Information. Please use one form per claim.

Claim Number:	Date(s) of Service From/To:	Type of Service:	Provider Name/ Address/Telephone Number:
		☐ Medical ☐ Dental ☐ Prescription ☐ Vision	

Section 3. Grievance Information. Please provide specific information regarding your request for grievance in the space below. Attach additional sheets of paper if necessary.

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Section 4. Documentation. Please include specific documentation that supports the necessity for a comprehensive review of the claim. Duplicate information on file will not be considered for a grievance.

Additional documentation attached? ☐ Yes ☐ No

Section 5. Authorization. I declare that the above information is true and accurate to the best of my knowledge.

Enrollee/Provider Signature:	Date:

Complete and return to: 2425 James Street
Syracuse, NY 13206
OR
315-433-5445 Fax