Grievance Form

Use this form to request review of an action by Premier Access affecting your benefits.

Number: _____

Reason for Grievance

- ☐ Amount of payment for covered services
- ☐ Denial of authorization for services
- ☐ Amount of premium billed
- ☐ Eligibility for COBRA
- ☐ Waiver of waiting period
- ☐ Quality of dental services received
- ☐ Other *(specify)*: _____

Subscriber (Employee) Information

Social Security Number: _____ Date of Birth: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Email Address: _____

Grievant Information (if different from subscriber)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Explanation of Grievance (attach additional pages, if needed, and any other documentation)

Signature: _____ Date: _____

Fax: 602.638.5956
GrievanceDept@premierlife.com

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