

DATE: \_\_\_/\_\_\_/\_\_\_  
APPELLANT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER

BUSINESS: (\_\_\_) \_\_\_\_\_

HOME: (\_\_\_) \_\_\_\_\_

FAX: (\_\_\_) \_\_\_\_\_

Please provide the reason for requesting this appeal or investigation of your grievance. Include original issue/complaint, statement of original issue and brief summary.

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I authorize and direct TRIAD Healthcare, Inc. to investigate the issues described above. I authorize any party identified above to release information pertaining to this investigation to TRIAD's Clinical Director upon her/his written request.

\_\_\_\_\_  
Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Date

Please submit this form and all documentation to the above address or fax to 860-793-3317.