DavisVision
by VersantHealth

Privacy Grievance

Date: _____ **Member ID:** _____

Name: _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

_____ **Email:** _____

You have the right to file a grievance with Davis Vision about our privacy practices or our compliance with our Privacy Practices Notice, our Privacy Policies and Procedures, or federal or state privacy rules or law. Davis Vision will investigate your grievance and provide you with a written response. Davis Vision will not require you to waive any right you may have under federal or state privacy or other law to file your grievance, nor will filing your grievance adversely affect your enrollment in Davis Vision, your eligibility for benefits under Davis Vision, or the payment of your claims by Davis Vision. To exercise this right, please complete, sign and date the below sections, then mail or fax this complaint to Davis Vision at:

Davis Vision – Privacy Office
P.O. Box 472
Troy, New York 12181
Fax: 1-866-999-4640

If you have questions, need additional information or assistance in completing your grievance, please contact the Davis Vision Privacy Office at 1-800-571-3366 or the address shown above. You may, in addition or in the alternative to filing a grievance with us, file a grievance with the United States Department of Health and Human Services.

Please give a concise, plain statement of your grievance:

_____
_____
_____
_____

Please give a concise, plain statement of the resolution you seek for your grievance:

_____
_____
_____
_____

Signature: _____ **Date:** _____
(Person Submitting Grievance)

If this form is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

PLEASE RETAIN A COPY OF GRIEVANCE FOR YOUR RECORDS