
## Grievance, Appeal, Concern or Recommendation Form

If you wish to file a grievance, appeal, concern or recommendation, please complete this form. If you choose not to complete this form, you may write a letter that includes the information requested below. The completed form or your letter should be mailed to:

**Buckeye Health Plan**
**Appeal Department**
**4349 Easton Way, Suite 400**
**Columbus, OH 43219**
**Phone 1-877-687-1189**
**TDD/TTY 1-877-941-9234**
**Fax 1-866-258-4102 (Appeal)**
**Fax 1-877-865-0992 (Grievance/Complaint)**

Member's Name:_____

Member's Ambetter #:_____

Street Address: _____

_____

City State Zip

Member Phone Number:_____

Tracking Number (if applicable. Found in upper left hand corner of denial letter):

_____

Additional information to support the grievance, appeal, concern or recommendation (or attach):

_____

_____

_____

_____

_____

**Member or Representative:** _____

**Daytime Phone #:**_____ **Date:**_____

***You must file an appeal within 180 calendar days of the date of the denial letter.***
***You must file a grievance within 180 calendar days of the date of the event.***


AMB16-OH-C-00048