



### 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:

Ambetter from Western Sky Community Care  
Attn: Appeals and Grievances Department  
PO Box 10341  
Van Nuys, CA 91410  
Phone: 1-833-945-2029 (Relay 711)  
Fax: 1-833-886-7956

Member's Name: \_\_\_\_\_

Member's Ambetter #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member Phone Number: \_\_\_\_\_

For an Appeal request, provide the Tracking/Authorization Number of your denial:  
\_\_\_\_\_

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 from the date noted on your adverse determination notice (denial).***

***\*You may file a grievance at any time.***