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 Health
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

Iowa Members, contact us by telephone at: 1-833-919-3213 (TTY 711)

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.

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AMB18-IA-C-00245