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 Arizona Complete Health
Appeal Department
PO Box 277610
Sacramento, CA 95827
Phone 1-888-926-5057
TDD/TTY 1-888-926-5180
Fax 1-877-615-7734 (Grievances & Appeals)

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.