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 Louisiana Healthcare Connections
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
Phone: 1-833-635-0450 (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.

© 2022 Louisiana Healthcare Connections, Inc. All rights reserved.
AMB18-LA-C-00245