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

Phone: 1-877-687-1182 (TTY 1-800-743-3333)

Member's Name: _____

Member's Ambetter ID #: _____

Street Address: _____

_____

City State ZIP code

Member's Phone Number: _____

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

_____

Additional information to support the grievance, appeal, concern or recommendations (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 must file a grievance within 180 calendar days of the event.

AMB19-IN-C-00340