



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: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956
Phone: 1-833-543-3145 (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 letter).***

Appeals and Grievances

Helpful Definitions



How to determine whether you need to file an Appeal or a Grievance, which can include expressing a Concern or providing a Recommendation.

- **Appeal (or internal appeal)** means a review of an adverse benefit determination by the plan to decide if the decision to deny benefits or services was appropriate. The appeal is your dispute of the adverse benefit determination made by the health plan. The appeal decision can be based on new information received from you, your authorized representative, or your provider or simply a review of the original information submitted if there is no additional evidence or supporting documentation to provide for the appeal review.
- **Grievance** means an expression of dissatisfaction about any matter (except an adverse benefit determination). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect your rights regardless of whether remedial action is requested. A grievance includes your right to dispute an extension of time proposed by the plan to make a decision. Some of your concerns may also be addressed quickly by calling Member Services and may not require you to file a grievance, but it is your right to do so.

Other terms that will assist you when filing an Appeal or Grievance and when getting a resolution from us.

- **Adverse Benefit Determination** means any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit.
- **Authorization (or Prior Authorization)** means a decision by the health plan to approve specialty or other medically necessary care requested by your PCP or provider group prior to receiving services.
- **Final Adverse Benefit Determination** means an adverse benefit determination, including medical judgment or a covered benefit, that has been upheld by the health plan at the completion of our internal appeal review.
- **External Review (or External Appeal)** means a second review of our decision to deny coverage for a service and is done by an independent third-party, who is not connected with us in any way. An external review either upholds the health plan's decision or overturns all or some of the health plan's decision. The health plan must accept their decision.
- **Overturn** means the prior decision is not confirmed and has been reversed on (internal/external) appeal.
- **Upheld** means the prior decision is supported and will remain as the final (internal/external) appeal decision.

Learn about how to get the most out of your plan. Refer to your Evidence of Coverage (EOC) for more information, including the Appeals and Grievances process, by visiting: AmbetterHealth.com/en/health-plans/.

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