



**Complaint, Grievance, Concern or Recommendation Form**

If you wish to file a complaint, grievance, 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 PA Health & Wellness  
Attn: Appeals and Grievances Department  
PO Box 10341  
Van Nuys, CA 91410  
Phone: 1-833-510-4727 (Relay 711)  
Fax: 1-833-886-7956

Member's Name: \_\_\_\_\_

Member's Ambetter #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member Phone Number: \_\_\_\_\_

For a Grievance request, provide the Tracking/Authorization Number of your denial:

\_\_\_\_\_

Additional information to support the grievance, concern or recommendation (or attach):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Member or Representative: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

***\*You must file a grievance within 180 calendar days from the date noted on your adverse determination notice (denial).***

***\*You may file a complaint at any time.***