



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 Absolute Total Care
Attn: Grievances and Appeals Department
12515-8 Research Blvd, Suite 400, 3rd Floor
Austin, TX 78759
Phone: 1-833-270-5443 (Relay 711)
Fax: 1-833-886-7956

Member's Name: _____

Member's Ambetter Number: _____

Street Address: _____

City State Zip

Member's 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 Number: _____ Date: _____

****You must file a grievance within 120 calendar days from the date of the event.***

You must file an appeal within 180 calendar days from the date noted on your adverse determination notice.