



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

Indiana Members, contact us by telephone at: 1-877-687-1182 (TTY 1-800-743-3333)

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 must file a grievance within 180 calendar days of the event.***