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:

Home State Health
Appeal Department
11720 Borman Drive
St. Louis, MO 63146
Phone 1-855-650-3789
TDD/TTY 1-877-250-6113
Fax 1-855-805-9812 (Grievances & Appeals)

Member's Name: ____

Member's Ambetter #: ____

Street Address: ____

City State Zip

Member 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 #: **Date:**

You must file an appeal within 180 calendar days of the date of the denial letter.
You must file a grievance within 180 calendar days of the date of the event.

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