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:

For Appeals:
Ambetter from Home State Health
Attn: Appeals Department
7711 Carondelet Ave. St.
Louis, MO 63105
Fax: 1-855-805-9812

For Grievances & Concerns:
Ambetter from Home State Health
Attn: Grievances Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

Contact us by telephone at: 1-855-650-3789 (TTY 711)

Member's Name: _____

Member's Ambetter ID #: _____

Street Address: _____

_____

City State ZIP code

Member's Phone Number: _____

For an Appeal request, provide the Tracking/Authorization Number of your denial:

_____

Additional information to support the grievance, appeal, concern or recommendations (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 can file a grievance at any time.

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 and definitions, by visiting: **Ambetter.HomeStateHealth.com/health-plans.html.**

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