MEDICAID MEMBER
APPEAL/GRIEVANCE REQUEST

If you want to appeal the decision we have made, you can write a letter or fill out this form and send it to us within 60 calendar days from the date on the Notice of Adverse Benefit Determination for a regular appeal. You can also call us within 60 calendar days from the date on the Notice of Adverse Benefit Determination. If you call us first, you must still send a letter or this form to us within 10 business days after you called us.

If you or your doctor thinks your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination letter, you or the doctor acting on your behalf can ask for an expedited (quick) appeal by calling us. If you call us to request a quick appeal, you do not need to send Molina this form.

Check this box to have your appeal/grievance processed as expedited ☐

If your appeal does not qualify for an expedited (quick) appeal you will need to submit your written request within 10 business days. We will notify you if your appeal does not qualify for a quick appeal.

If you want help in filling out this form, please call (800) 578-0603 for Medicaid.

Who is requesting this appeal (check one)?

☐ Member ☐ Authorized Rep/Provider Date: _____

MEMBER INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _____

Member ID Number_____

Member Address: _____

City: _____ State: _____ Zip: _____

Member Phone #: _____Member Email: _____

Reason for Appeal: __ _____

_____

_____

HEALTHCARE PROVIDER INFORMATION:

Doctor Name: _____

Doctor Address: _____

City: _____ State: _____ Zip: _____ _____

Name of Contact at Doctor's office: _____ ____ _____

Doctor Phone #: _____ Doctor Fax #: _____

Reason for Appeal: _____ _____

_____

_____

*****Please attach any information that will feel will help us to understand your medical condition and your appeal and send it to:**

Passport Health Plan by Molina Healthcare.
Attn: Member Appeals Department
5100 Commerce Crossing

Louisville, KY
Toll Free Number: (800) 578-0603
Fax: 833-415-0673
Email: MHK_Enrollee_GnA@MolinaHealthCare.Com

Authorized Representative Permission Statement

If your health care provider or another individual is filing the appeal/grievance for you, you must give your written permission.

I, _____ (your name), give my permission

for _____ (designee) to file this Appeal/Grievance Form on my behalf.

_____ _____
Member Signature Date

***Note** All requests for appeal MUST be accompanied by supporting documentation from the requesting provider.*