Molina Healthcare of Wisconsin, Inc.
Grievance Form

If you want to file a standard or expedited grievance to dispute this determination, fill out this form and send it to Molina within one hundred and eighty (180) days of the date of the adverse benefit determination or final adverse benefit determination.

If your health care provider thinks your life or health is in immediate danger because of the decision in the adverse benefit determination, he/she can ask for an expedited grievance by either calling Molina Healthcare of Wisconsin, Inc. or by completing this form.

If you have questions or need help completing this form, call 1 (888) 560-2043, TTY/TDD: 711.

Please Print

Date: _____

Member ID #: _____

Member LAST name: _____ Member FIRST name: _____

MI: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Doctor Name: _____

Specific Issues: _____

_____

Mail, email or fax all supporting documentation regarding your grievance to:

Molina Healthcare of Wisconsin, Inc.
Attn: Grievance Coordinator
11002 W. Park Place
Milwaukee, WI 53224
Fax: 1-844-251-1445
grievance.online@MolinaHealthcare.com

(see and complete next page)

Authorized Representative Permission Statement

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

I, _____ (your name), give my permission

for_____ (designee) to file this Grievance Form on my

behalf.

_____ _____

Member Signature Date

Check this box to have your appeal processed as expedited ☐

"**Note** All requests for an expedited appeal MUST be accompanied by supporting documentation from the requesting provider, indicating the reason for the expedited request.