P. O. Box 182273
Chattanooga, TN 37422

Molina Healthcare
Member Grievance/Appeal Request Form

Instructions for filing a grievance/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit. (Do Not Send Originals).
3. If you have someone else submit on your behalf, you must give your consent below.
4. You may submit the completed form through one of the following ways:
    a. Send to the address listed below,
    b. Fax to the fax number below

We will send a written acknowledgement letter of your request. It will be mailed to you within five (5) working days after the request is received.

Member's name: _____ Today's date: _____

Name of person requesting grievance/appeal, if other than the Member: _____

Relationship to the Member: _____

Member's ID #: _____ Daytime telephone #: _____

Specific issue(s): _____

_____

_____

_____

_____

(Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed)

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature: _____ Date: _____

If you would like help with your request, we can help. We can help you in the language you speak or if you need other special support for hearing or seeing. You can call, write or fax us at:

Molina Healthcare of Texas
Attn: Grievance & Appeal Department
P. O. Box 182273
Chattanooga, TN 37422

Molina Healthcare Member Services: 1-888-560-2025
Hearing Impaired TTY/TX Relay: 1-800-735-2989 or 711
Fax Number: 1-877-816-6416

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Molina Healthcare cannot promise that the way in which you submit this form to us is a secured method.

Thank you for using the Molina Healthcare Member Grievance & Appeal Process.

Important Information You Need to Know

- If you are unhappy with the steps we and/or your doctor took for your request, let us know. You can fill out the enclosed *Member Grievance/Appeal Request Form* to file an appeal. You may also call us.
- If you or your doctor think that waiting for the grievance to be processed would be life threatening, or could cause serious harm to your health, please let us know why you think this. This is called an expedited appeal. We will make a determination within one working day of the appeal request whether to expedite the appeal. If we agree, we will let you know within three (3) working days of your appeal. If we do not agree, your appeal will be resolved within the normal processing time.
- If you would like to continue your care that you currently are getting during this process, please submit a request in writing within ten (10) days of your denial notice. If a decision is made and it is not in your favor, you may be responsible for the cost of the care received during this process.

Molina Healthcare Member Services: **1-888-560-2025**
Hearing Impaired TTY/TX Relay: **1-800-735-2989 or 711**
9 a.m. to 5 p.m. Monday through Friday

- ***Return this completed form to:***
  Molina Healthcare of Texas
  Attn: Grievance & Appeal Department
  P. O. Box 182273
  Chattanooga, TN 37422

We will send a written confirmation of receipt of your request, and separately, will respond to your request.

Thank you for advising us of your concerns.

This form is available on our website at www.MolinaHealthcare.com.