

 \Box Other, please specify:

Please see information on "How to File an Appeal or Grievance" on the second page of this form.

Part I. Member Information

Member First Name:	Member Last Name:
Member ID #:	Member DOB:
Member Address:	
City, State, Zip Code:	
Member Phone #:	

Part II. Appeal or Grievance Information

Tell us about your appeal or grievance. Please give us all the information you have. If you are filing an appeal, you have 60 days from the day you receive the letter about an adverse decision. Add another sheet of paper to this form if more space is needed.

Part III. Relationship to Member

*Documents showing Legal Guardianship or Power of Attorney must be provided to us.

 \Box Self

□ Parent

□ Guardian*

 \Box Power of Attorney*

Member Signature:

Today's Date: _____

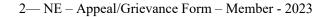
How to File an Appeal or Grievance:

- 1. This form gives us the information needed to help you with your appeal or grievance. Fill out each part of this form. Describe the issue(s) in as much detail as possible. Include your signature.
- 2. Please write clearly and in **print**.
- 3. If you have information you want to include with this form, attach copies (Do Not Send Originals). Some examples of information to include could be a copy of a bill you received from a doctor or medical records.
- 4. You may present information in person. To do this, call our Member Services Help Line at 1-844-782-2018.
- 5. We can help you write your request, and we can help you in the language you speak. If you need services for the hard of hearing, you may call our TTY/TTD phone number at 711.
- 6. If you are a legal guardian or Power of Attorney filing an appeal or grievance for our member, you must send us the documents showing this.
- 7. If you are over the age of 18, you can have someone else file your appeal or grievance for you with your written consent. This is called an Authorized Representative. Your Authorized Representative can be your provider, a relative, friend, and even an attorney.
 - To give your written consent, use the Appointment of Representative (AOR) Form enclosed.
- 8. You or someone you have chosen to act on your behalf, can review your appeal file before or during the appeal process. Your appeal file includes all your medical records and any other documents related to your case. You can request this by calling our Member Services Help Line at 1-844-782-2018.
- 9. Return this completed form and any extra information related to your appeal or grievance to:

Molina Healthcare of Nebraska Appeal and Grievance Unit P.O Box 182273 Chattanooga, TN 37422 Fax: 1-833-635-2044

- 10. You may also submit your appeal or grievance via your My Molina Portal.
- 11. We will let you know in writing that we received your appeal or grievance within 10 calendar days. If you filed an expedited (fast) appeal, you would receive a notice in writing within 72 hours.

Thank you for using the Molina Healthcare of Nebraska Appeal and Grievance process.





Member Appointment of Representative (AOR) Form

Part I. Member Information	
Member First Name:	Member Last Name:
Member ID #:	Member DOB:
Part	II. Authorized Representative Information
First Name:	Last Name:
Phone #:	Relationship to Member:
Address:	
City, State, Zip Code:	
I	Part III. Appointment of Representative
I,	, agree to name
(Member N	ame)
	to be my authorized representative
(Representativ	ve Name)
during my appeal or grievance about	
	(Specific Issue)
-	n consent for the mentioned representative to act on my behalf during the Health Information related to my appeal or grievance may be given to my
□ I understand that my authorized re my appeal or grievance, which may in	presentative can make requests or provide Molina with information related to aclude Personal Health Information.
Member Signature:	Today's Date:
Representative Signature:	Today's Date:

