Medicaid Grievance (Complaint) Form

Section A: Member Information

Last Name	First Name		Initial
Date of Birth (MM/DD/YY)	Date of Incident		
Mailing Address	City	State	Zip
Evening Phone Number	Daytime Phone Number	Contact Hours (Please specify when you prefer to be called)	
Member Number			

Section B: Please give a detailed reason for your grievance (complaint):

Section C: Signature

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

Signature _____ Date _____

If the complaint is filed by a personal representative on behalf of the member, complete the Consent for Authorized Representative Form and return with grievance form.

Signature of Personal Representative _____ Date _____

☐ Parent of Minor Child ☐ Legal Guardian ☐ Power of Attorney ☐ Executor/Conservator

☐ Other _____

Please return form(s) to:

Molina Healthcare of California
Attn: Member Appeals and Grievance
PO BOX 401820
Las Vegas, NV or
Fax 877-823-5961

The Nevada Medicaid Hearings Unit is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-833-685-2102, TTY users dial 711** and use your health plan's grievance process before contacting the Nevada Medicaid Hearings Unit. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The Nevada Medicaid Hearings Unit also has a toll-free telephone number **(877) 638-3472**, Fax # (775) 684-3610 and E-mail: dhcfphearings@dhcfp.nv.gov.

Consent for Authorized Representative Form

If you want someone else to file an Appeal for you, or for Molina to discuss your appeal with someone else, you must give your written consent for the Appeal.

I, _____ (Member's Name), give my permission

for _____ (Authorized Representative's Name) to

act on my behalf and file this appeal to review the denial of _____.

_____ _____

Member's Signature Date