

## Molina MyCare Ohio Medicaid 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, or
  - c. Present your information in person. To do this, call us at the number listed below.

We will send a written acknowledgement letter of your request. It will be mailed to you within three 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 Ohio, Inc.  
Grievance & Appeals Unit  
P.O. Box 182273  
Chattanooga, TN 37422

**Molina MyCare Ohio Medicaid Member Services:** (855) 687-7862 (TTY 711)

Monday to Friday, 8 a.m. to 8 p.m. local time

**Fax Number:** (866) 713-1891