Instructions for filing a complaint/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 five (5) working days after the request is received.

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

Name of person requesting complaint/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 Member Services: 1-866-449-6849
Hearing Impaired TTY/TX Relay: 1-800-735-2989 or dial 711
Texas Relay Spanish (800) 662-4954

Molina Healthcare of Texas
Attn: Member Inquiry Research and Resolution Unit
P. O . Box 165089
Irving, TX 75016

Fax Number: 1-877-816-6416

Thank you for advising us of your concerns.

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