Molina Healthcare of Wisconsin, Inc.
Grievance/Appeal Consent Form

Grievances can be requested at any time, by phone or in writing. A Grievance is any concern/dissatisfaction about your health plan or health provider that is not related to an adverse benefit determination.

To dispute an adverse benefit determination (a denial, reduction, or partial approval of a service/benefit or failure to make payment in whole or in part for services received) you can request an Appeal. You may request to appeal for up to 60 days after receiving your adverse benefit decision. Include all supporting documents to request an Appeal.

Your health care provider can ask for an* Expedited Appeal *by calling Molina or completing this form. If your provider thinks your life or health is in immediate danger because of the decision in the adverse benefit determination, that means you need an Expedited Appeal.

For help completing this form, call Molina at 1 (888) 999-2404, TTY/TDD: 711, between 8 a.m.-5 p.m.

Please Print

Date: _____

Member ID #: _____

Member LAST Name: _____ Member FIRST Name: _____ MI: _____

Current Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Doctor's Name: _____

Specific Issues: _____

_____

Mail, email or fax all supporting documentation for your grievance to:

Molina Healthcare of Wisconsin, Inc.
Attn: Grievance Coordinator
PO Box 242480
Milwaukee, WI 53224-9931
Fax: 1-844-251-1445
WIMemberAppeals@MolinaHealthcare.com

Authorized Representative Permission Statement

You must give your written permission if your health care provider or someone else is filing the grievance for you. Complete the following:

I, _____ (your name), give my permission for

_____ (designee) to file this Grievance Form on my behalf.

_____ _____
Member Signature Date

Check this box to have your Appeal expedited. ☐

*****Note** All requests for an Expedited Appeal MUST have supporting documentation from the requesting provider, stating why there is a need for an expedited request.***