Grievance and Appeals Form

If you wish to file a grievance, appeal, concern or recommendation, please complete please complete this form. If you choose not to complete this form information requested below. The completed form or your letter should be mailed to:

Ambetter from MHS
Attn: Appeals & Grievances Department
P.O. Box 441567
Indianapolis, IN 46244
Phone 1-877-687-1182
TDD/TTY 1-800-743-3333
Fax 1-866-714-7993

Member's Name:_____

Member's Ambetter #:_____

Street Address: _____

_____

City State Zip

Member Phone Number:_____

Tracking Number (If applicable. Found in upper left hand corner of denial letter):

_____

Additional information to support the grievance, appeal, concern or recommendation (or attach):

_____

_____

_____

_____

_____

Member or Representative: _____

Daytime Phone #:_____ **Date:**_____

You must file an appeal within 180 calendar days of the date of the denial letter.
You must file a grievance within 180 calendar days of the date of the event.

AMB19-IN-C-00340