Grievance, Appeal, Concern or Recommendation Form

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

Ambetter from Absolute Total Care
Attn: Grievances and Appeals Department
12515-8 Research Blvd, Suite 400, 3rd Floor
Austin, TX 78759
Phone: 1-833-270-5443 (Relay 711)
Fax: 1-833-886-7956

Member's Name:____

Member's Ambetter Number: ______________________________________

Street Address: ____

______________________________ ____________________ __________
City State Zip

Member's 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 Number:__________________ **Date:**______________________

You must file an appeal within 180 calendar days from the date noted on your adverse determination notice.

You may file a grievance at any time.

© 2019 Absolute Total Care. All rights reserved.
AMB18-SC-C-00245