

Concerns and Recommendations

HELP US IMPROVE HOW WE SERVE OUR MEMBERS

We're always looking for ways to improve, so if you have concerns or ideas, please let us know! If you don't want to use this form, you can mail us a letter that includes in information below instead. Thank you!

Member Name: _____

Member Medicaid #: _____

Member Address: _____

City: _____ State: _____ Zip: _____

Member Phone: _____

Tracking Number (if applicable; found in upper left corner of denial letter): _____

Your concern or recommendation (you can attach more pages if needed):

Signature (Member or Member's Representative): _____

Daytime Phone: _____ Date: _____



SEND YOUR COMPLETED FORM TO:

Louisiana Healthcare Connections, ATTN: Member Services
8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809

Or fax to: 1-866-768-9374



HAVE QUESTIONS OR NEED HELP?

Call us at 1-866-595-8133 (hearing loss: 711), Monday through Friday, 7 a.m. to 7 p.m.