Grievance or Appeal

HELP US IMPROVE HOW WE SERVE YOU

We hope our members will always be happy with our providers and with us. But if you are not happy, we want to know so we can resolve any concerns you have. To file a grievance or appeal, please complete this form and send it to us within 30 days of the event or denial letter. 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): _____

Description of your grievance or appeal (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: Quality
8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809

Or fax to: 1-877-401-8170

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.