MOLINA HEALTHCARE
Your Extended Family.

Molina Healthcare

Member Grievance/Appeal Request Form

Instructions for filing a grievance/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit. (Do not send originals).
3. If you have someone else submit on your behalf, you must give your consent below.
4. You may submit the completed form through one of the following ways:
   a. Send to the address listed below,
   b. Fax to the fax number below, or
   c. Present your information in person. To do this, call us at the number listed below.

Molina Healthcare cannot promise that the way you submit this form to us is a secured method. For example, submitting this form via mail or fax may not be secure.

We will send a written acknowledgement letter of your request. It will be mailed to you within three (3) working days after the request is received.

Member's name: _____ Today's date:_____

Name of person requesting grievance/appeal, if other than the Member: _____

Relationship to the member: _____

Member's ID #: _____ Daytime telephone #:_____

Specific issue(s): _____

_____

_____

_____

(Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed.)

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature: _____

Date:_____

If you would like help with your request, we can help. We can help you in the language you speak or if you need other special support for hearing or seeing. You can call, write or fax us at:

Molina Healthcare of Ohio
Attn: Grievance & Appeal Department
P.O. Box 349020
Columbus, Ohio 43234-9020

Molina Healthcare Member Services: (800) 642-4168
Hearing Impaired TTY/Ohio Relay: (800) 750-0750 or 711
Fax Number: (866) 713-1891