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:

Buckeye Health Plan
Appeal Department
4349 Easton Way
Suite 200
Columbus, OH 43219
Phone 1-877-687-1189
TDD/TTY 1-877-941-9236
Fax 1-866-258-4102 (Appeal)
Fax 1-877-865-0992 (Grievance/Complaint)

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.