



## Mountain Health Co-Op Member Complaint Form

Please use the **Appeal Form** to appeal an adverse benefit determination (denied or limited authorization request) or a claim benefit denial where the member could be liable for payment.

For Retail Pharmacy appeals (a medication dispensed to a member from a retail or specialty pharmacy), please use the **Retail Pharmacy Appeal Form**.

For Medical Pharmacy appeals (a medication administered to a member in a facility setting, provider or infusion center, or in the home dispensed from a home infusion pharmacy), please use the **Appeal Form**.

For Provider Disputes of claim billing denials or contract payment amounts, please use the **Provider Dispute Form**.

For any other concerns, complaints or grievances, please use this form.

**If you need help filling out this form, call us at 800-299-6080 (TTY Users: 711).**

### Request Type

- New Complaint Submission       Additional Information for Existing Complaint

### Priority

- Routine       Expedited

### Type of Service

- Medical       Medical Pharmacy Medication       Behavioral Health

## Member Information

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### I am the...

- Contracted Provider       Member  
 Customer Service Representative       Non-Contracted Provider  
 Authorized Representative for the Member (Please be sure you have a signed AOR/Consent Form, included)

### If you are not the member, please provide...

Your Name \_\_\_\_\_ Your phone number \_\_\_\_\_



Member's Name \_\_\_\_\_ Member ID Number \_\_\_\_\_

Member Street Address \_\_\_\_\_

Member 2<sup>nd</sup> Street Address \_\_\_\_\_

Member City \_\_\_\_\_ Member State \_\_\_\_\_ Member Zip Code \_\_\_\_\_

Member Phone Number \_\_\_\_\_

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### Provider Information

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Provider NPI \_\_\_\_\_ Name of Provider Involved \_\_\_\_\_

Provider Street Address \_\_\_\_\_

Provider City \_\_\_\_\_ Provider State \_\_\_\_\_ Provider Zip Code \_\_\_\_\_

Provider Phone Number \_\_\_\_\_ Provider Fax Number \_\_\_\_\_

Provider Specialty \_\_\_\_\_

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### Complaint Information

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Date(s) of Service Related to Complaint \_\_\_\_\_

Claim Number(s) If Applicable \_\_\_\_\_

Referral Number If Applicable \_\_\_\_\_

The Reason(s) for the Complaint (Please be Specific and Include Details)



## Email Confirmation

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Confirmation Email \_\_\_\_\_

Please include supporting documentation after this form.

If you need to file a complaint about the services provided by your health plan, the customer service received from your health plan, provider, or provider's office staff, the quality of care you received from one of our providers, the quality of a provider's office site, the availability of appointments or certain provider types, or need to express any other dissatisfaction with your health plan, you can contact us in any of the below ways:

Submit via Mail:

Mountain Health Co-Op  
PO Box 5358  
Helena, MT 59604

Call us: 800-299-6080

Submit via Fax: 406-513-1045

Submit Online via Email: [complaint@mhc.coop](mailto:complaint@mhc.coop)