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

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 2nd Street Address_____

Member City_____ Member State_____ Member Zip Code_____

Member Phone Number_____

Provider Information

Provider NPI_____ Name of Provider Involved_____

Provider Street Address_____

Provider City_____ Provider State_____ Provider Zip Code_____

Provider Phone Number_____ Provider Fax Number_____

Provider Specialty_____

Complaint Information

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

Confirmation Email _____

Please include supporting documentation after this form.

If you would prefer to fax the information to the Appeals Team, please use fax number 1-559-243-7012. If you would prefer to mail the information to the Appeals Team, please use:

HealthComp UM Department
PO Box 45018
Fresno, CA 93718-5018