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 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