



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:

Ambetter from Arkansas Health & Wellness
ATTN: Appeal Department
PO Box 25538
Little Rock, AR 72201
1-877-617-0390
TDD/TTY 1- 877-617-0392
Fax 1-866-811-3255

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.***