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 72221
1-877-617-0390
TDD/TTY 1- 877-617-0392
Fax 1-877-617-0393

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):

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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.

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