Steps for filing a Grievance/Appeal

Molina Healthcare
Member Grievance/Appeal Request Form

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit (do not send originals).
3. If you have someone else submit on your behalf, you must give your consent below.
4. You may submit the completed form through one of the following ways:
   a. Send to the address listed below;
   b. Fax to the number below; or
   c. Email to MNM.Medicaid.MemberAppealsandGrievances@molinahealthcare.com

Check one: ___Grievance ____Appeal
We will send a written acknowledgement letter of your request. It will be mailed to you within five (5) business days after the request is received.
Member's name: _____ Today's date:_____
Name of person requesting grievance/appeal if other than the Member: _____
Relationship to the Member: _____
Member's ID #:_____
Daytime telephone #:_____
Specific issue(s):_____
_____
_____
(Please state all details relating to your requests including names, dates, and places. Attach another sheet of paper to this form if more space is needed.)
By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.
Member's Signature: _____

Date: _____

If you would like help with your request, we can help. We can help you in the language you speak or if you need other special support for hearing or seeing. You can call, write, or fax us at:

Molina Healthcare of New Mexico, Inc.
Attn: Appeals & Grievances Department
PO Box 182273
Chattanooga, TN 37422

Molina Member Services: (844) 862-4543
Hearing Impaired TTY/NM Relay: 1-800-659-8331 or 711
Fax Number: (505) 342-0583

Such services are funded in part with the State of New Mexico

Important Information You Need to Know

- If you have questions about the steps we and/or your provider took for your request, let us know. You can fill out the enclosed *Member Grievance/Appeal Request Form* to file either a grievance or an appeal. You may also call us.
- If you or your provider think that waiting for the grievance to be processed could cause serious harm to your health, please let us know. This is called an expedited appeal. If we do not agree, your appeal will be resolved within the normal processing time.
- If you would like to continue the care that you currently are getting during this process, please submit a request in writing within ten (10) days of your denial notice. If a decision is made and it is not in your favor, you may be responsible for the cost of the care during this time.
- If the Appeal is initiated by Molina, your continuation of benefits is automatic, and you will not pay for using the continued benefit.

Return this completed form to:

Molina Healthcare of New Mexico, Inc.
Attn: Appeals & Grievances Department
PO Box 182273
Chattanooga, TN 37422

We will send a written confirmation of receipt of your request, and separately, will respond to your request. Thank you for advising us of your concerns.
This form is available on our website at www.MolinaHealthcare.com.

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