Nevada Appeals and Grievance form

Section A: Member information

Last name		First name			Initial
Date of Birth (MM/DD/YY)		Authorization number and denial date			
Mailing address		City	State		ZIP
Evening Phone	Daytime Phone	Contact hours (Please specify when you prefer to be called)			
Member ID					

Section B: Please give a detailed reason for your appeal or grievance:

Section C: Signature

I certify that the statements made in this appeal or grievance are true and correct to the best of my information and belief.

Signature

Date

If the appeal or grievance is filed by a personal representative on behalf of the individual, complete the following and check the appropriate box. Print name of personal representative:

Signature of personal representative

Date

☐ Parent of minor child ☐ Legal guardian ☐ Power of Attorney ☐ Executor/Conservator

☐ Other

Please return this form and supporting documents to:
Molina Healthcare, Inc.
Attn: Nevada Member Appeals and Grievances
PO Box 182273
Chattanooga, TN 37422 or
Fax (833) 412-3145

Non-Discrimination Notice
Molina Healthcare of Nevada
Marketplace

Molina Healthcare of Nevada (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina does not discriminate on the basis of race, color, national origin, age, disability, or sex. This includes gender identity and sexual orientation.

To help you communicate with us, Molina provides the following services free of charge:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in other languages
  - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (833) 671-0051 (TTY: 711) Monday – Friday, 8 a.m. to 6 p.m. PST.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or e-mail. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at
(866) 606-3889 (TTY: 711). Mail your complaint to:
Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can e-mail your complaint to civil.rights@molinahealthcare.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.
You can mail it to:
U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Bldg.
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf or call (800) 368-1019, TTY (800) 537-7697.

Distribuido por Molina Healthcare of Nevada, Inc. (Molina). Para obtener esta información en otros idiomas y formatos accesibles, llame al Departamento de Servicios para Miembros. Este número telefónico se encuentra al reverso de su tarjeta de identificación del miembro. Puede solicitar esta información sin costo en otros formatos, como letra grande, sistema Braille o audio. Llame al (833) 671-0051 (TTY/TDD: 711), de lunes a viernes, de 8 a. m. a 6 p. m., hora del Pacífico. Molina cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Consent for Authorized Representative Form

If you want someone else to file a grievance or appeal for you or for Molina to discuss your grievance or appeal with someone else, you must give your written consent for the grievance or appeal.

I, ____ (Member's Name), give my permission

for ____ (Authorized Representative's Name) to

act on my behalf and file this appeal to review the denial of __________________________ .

____ Member's Signature

________________ Date

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