DENVER HEALTH MEDICAID CHOICE

Health First COLORADO Colorado's Medicaid Program

Administered by Denver Health Medicaid Choice

MEMBER COMPLAINT AND APPEAL FORM

If you need assistance understanding the information in this document, including written or oral translation, we can help you. You can get help by calling **Denver Health Member Services Department** at **303-602-2116**, **1-800-700-8140**, or State Relay 711 for callers with speech or hearing disabilities. Si necesita esta carta en letras grandes, casete, o en otro idioma, por favor llámenos al 1-800-700-8140. Si desea usar el servicio TTY, llame a 711.

Completion of this form is voluntary. You or your authorized/personal representative must submit this request within 60 calendar days of an adverse benefit determination notification letter for an appeal or at any time for a grievance (also known as a complaint). Please attach copies of all documents which may support your request. If this is an urgent request please contact the Grievance & Appeals Department directly at 303-602-2261. This form and any accompanying documents may be mailed or faxed to:

Denver Health Medicaid Choice
Attn: Grievance and Appeals Department
938 Bannock Street
Denver, CO 80204
Fax: 303-602-2078
www.denverhealthmedicaid.org

Please provide the following information for the person the complaint or appeal is being submitted:

_____ _____
Name (Last, First, Middle Initial) Member ID #

_____
Home Address

_____ _____
City, State, Zip Code Telephone #

_____ _____
Medical Record # Date of Birth (MM/DD/YY)

If other than member listed above, please provide the following information for the person submitting the complaint or appeal:

_____ _____
Name (Last, First, Middle Initial) Telephone #

_____
Mailing Address

_____
City, State, Zip Code

Relationship to Member (check one): ◯ Spouse ◯ Son/Daughter ◯ Parent/Legal Guardian

◯ Friend/Significant Other ◯ Provider/Physician* ◯ Attorney

◯ Other (please specify) _____

*Important Note: By indicating a "check" in the Provider/Physician representation box above, **the provider and/or physician is acting on the member's behalf with the member's knowledge and approval.**

SECTION A: COMPLAINT: If this is in regards to a complaint, please describe the issue in the box below. If you are filing an appeal, please go to Section B. Include dates of service and staff names if applicable. You may use additional pages if necessary and/or attach supporting documentation.

SECTION B: APPEAL: If you wish to file an appeal to a previously denied service or claim, please provide the information requested below.

Is this in regards to a denied claim? ◯ Yes ◯ No

If yes, please provide the Claim #: _____

Date(s) of Service: _____

Provider Name: _____

Is this in regards to a denied medical service or treatment? ◯ Yes ◯ No

If yes, please provide the date of the Denial Letter: _____

Please describe in the space provided below the reason and a brief description of your appeal. You may use additional pages if necessary and/or attach supporting documentation.

_____ _____

Member Signature Date

_____ _____

Authorized Representative Signature Date

If you have any questions or need help completing this form, please contact the DHMC Grievance & Appeals Department at 303-602-2261 from 8:00 a.m. to 5:00 p.m. Monday through Friday. If we are unable to take your call, please leave a message and we will return your call within 48 hours.