

Member Grievance & Appeal Form

Medi-Cal



Date Filed: _____

Step 1: Complete the form below with your Alliance information.

| | |
|---|-----------------|
| Last Name: | First Name: |
| Alliance ID #: | Cell Phone #: |
| Date of Birth: | Other Phone #: |
| Address: | |
| City, State and Zip Code: | |
| <input type="checkbox"/> I request an expedited review because this issue involves a serious threat to my health. | |
| <input type="checkbox"/> I asked the following person or provider to help me with my grievance or appeal: | |
| Name of person: | Relationship: |
| If a provider, Provider Phone #: | Provider Fax #: |

Step 2: Describe what happened or what action you are appealing.

| | |
|--|-------|
| For appeals, what is the modified or denied authorization #: | |
| For a grievance, who is your grievance against? Provider Name: | |
| When did this happen? | Date: |
| Describe what happened: | |

Step 3: Sign and date this form.

I certify that the statements made above are true and correct to the best of my belief:

Member Signature: _____ Date: _____

Step 4: Return this form via email, fax or regular mail:

Regular mail: Alliance Grievance Department, 530 West 16th St., Ste. B, Merced, CA 95340
Email: grievancecoordinator@thealliance.health **Fax:** 831-430-5579