



nebraska
total care™

GRIEVANCE OR APPEAL FORM

This form is to help you file a grievance or appeal. You can fill it out and send it to us. Or, you may write a letter and include this information in your letter. Please mail or fax this form or your letter to:

Nebraska Total Care Appeals
2525 N. 117th Avenue
Omaha, NE 68164
Fax 1 -844 -655 -0567

Behavioral Health appeals:
Nebraska Total Care - Appeals
12515-8 Research Blvd, Suite 400
Austin, TX 78759
Fax 1-866-714-7991

****You must file an appeal within 60 days from the date on the denial letter.***

PLEASE PRINT

Member's Name: _____

Member's ID#: _____

Street Address: _____

City _____ State _____ Zip _____

Member Phone Number: _____

Tracking Number (if you have one). Found in the upper left hand corner of letter.

Share information you have about the grievance or appeal.

Representatives Name (if you name one) _____

Member/Representative's signature: _____

Daytime Phone #: _____ Date: _____