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:_____