GRIEVANCE FORM

This form is to help you file a grievance. 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 Grievances
2525 N. 117th Ave
Omaha, NE 68164
Fax 1-844-655-0567

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

***You must file a grievance 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.

_____

_____

_____

_____

_____

Representative's Name (if you name one): _____

Member/Representative's signature: _____

Daytime Phone #: _____ Date: _____