

# Kentucky Medicaid MCO Member Grievance Form

Check the box of the plan in which the member is enrolled	MCO	Phone	Fax
	<input type="checkbox"/> Anthem BCBS Medicaid	1-855-690-7784	1-855-443-7820
	<input type="checkbox"/> Coventry Cares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	<input type="checkbox"/> Humana – CareSource	1-877-892-7487	1-855-262-9194
	<input type="checkbox"/> Passport Health Plan	1-800-578-0603	502-585-8340
	<input type="checkbox"/> WellCare of Kentucky	1-877-389-9457	1-866-388-1769

**Please complete all appropriate fields**  
**If you need assistance with this form, call your MCO at the number listed above**  
**All Grievances must be filed within 30 days from the date of MCO action**

Date \_\_\_\_\_

Person filing grievance \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

I am a Medicaid member  I am filing a grievance on behalf of a Medicaid member

If filing on behalf of member, state relationship to member \_\_\_\_\_

**Who is the Grievance/Complaint about?**

Member’s name \_\_\_\_\_

Member’s SSN \_\_\_\_\_ Member’s Date of Birth \_\_\_\_\_

Member’s address \_\_\_\_\_ County \_\_\_\_\_

**What is the Grievance/Complaint about?**

- I am having trouble finding a healthcare provider
- I have a complaint about my doctor/healthcare provider
- I have a complaint about my facility and/or its staff (Nursing, Assisted Living, Adult Family Care Home, Hospice)
- I am receiving bills from healthcare providers
- I want to change my plan and need help
- I am a new member and have not received any plan information
- I am having trouble obtaining the following prescriptions: \_\_\_\_\_
- I am having trouble obtaining the following service: (Check all that apply)

<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Home Health
<input type="checkbox"/> Medical Equipment/Supplies	<input type="checkbox"/> Transportation	<input type="checkbox"/> Substance Abuse Treatment
<input type="checkbox"/> Occupational/Physical/Speech Therapy		<input type="checkbox"/> Other _____

Please give as much detail as possible about this complaint/grievance:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By signing this document, I authorize the person submitting this form to do so on my behalf

Signature of Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of person filing grievance \_\_\_\_\_ Date \_\_\_\_\_