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:	
☐ I request an expedited review because this issue involves a serious threat to my health.	
☐ 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@ccah-alliance.org **Fax:** 831-430-5579