GRIEVANCE, APPEAL, OR CONCERN 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 this form or your letter to:

SilverSummit Healthplan
Member Services
2500 North Buffalo Drive 2nd Fl.
Las Vegas, NV 89128
Fax 1-855-252-0568

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

***You may file a grievance at any time.**

***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: _____