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 or fax this form or your letter to:

NovumHealth
Attn: Grievance and Appeal Department
3321 N. Buffalo Dr., Suite 225
Las Vegas, NV 89129
Fax 1-702-857-8801

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 spoke to one)_____

Member/Representative's signature: _____

Daytime Phone #:_____Date:_____