Complaint and appeal form

Section 1 › Member and provider information

Name of person filing complaint		Telephone no.		
Address		City	State	ZIP
Subscriber name	Member name		Member ID no.	
Name of provider involved	Address		Telephone no.	
Name of provider involved	Address		Telephone no.	
Date(s) of service *(mm/dd/yyyy)*				

Section 2 › Complaint or appeal

Please write your complaint or appeal in the space below and on the back of this page. Include the reason for your appeal/complaint, a description of what happened, and your desired outcome. Attach additional pages if needed. You may include any document such as explanation of benefits (EOBs), medical/dental records, correspondence, or invoices which will help us investigate your complaint or appeal. **Please sign and date this form.**

I certify that the above information is accurate and complete to the best of my knowledge.

Signature	Date *(mm/dd/yyyy)*
X	

Ready to submit? Mail this form to Moda Health:
Attn: Appeal unit, P.O. Box 40384, Portland, OR 97240
or fax to 503-412-4003 or 866-923-0412.

Questions? Contact a customer service representative at 855-294-1668.

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