Member Grievance or Medical Necessity Appeal Form

If you wish to file a member grievance or medical necessity appeal, please complete this form. If you choose not to complete this form, you may write a letter that includes the information requested below. The completed form or your letter should be mailed to:

Peach State Health Plan
Grievance and Appeal Department
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

Phone 1-877-687-1180
TDD/TTY 1-877-941-9231
Fax 1-866-532-8855

Member's Name: ____

Member's Ambetter Number: ____

Street Address: ____

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City ______________________________________ State ________________ Zip ___________________

Member Phone: ____

Additional information to support the member grievance or medical necessity appeal (or attach):

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Member or Authorized Representative of the Member:

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Daytime Phone: Date:

***You must file an appeal within 180 calendar days of the date of the denial letter.**

***You must file a grievance within 180 calendar days of the date of the event.**

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