MEDICAID AND NEVADA CHECK UP

MEMBER GRIEVANCE FORM

Member/Insured Name: ____

Member Number: ______________________________ **Date of Birth**: ______________________

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

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Signature ***Date***

(If signed, a written response will be submitted to the member/insured)

WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:

COMPANY NAME:	Health Plan of Nevada
DEPARTMENT:	Customer Response and Resolution Department
MAILING ADDRESS:	PO Box 14865 Las Vegas, NV 89114-4865

As always, the Member Services Department can be contacted directly at 1-800-962-8074.