Grievance, Appeal, Concern or Recommendation Form

If you wish to file a grievance, appeal, concern or recommendation, 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
Member Services Department
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339
Phone 1-877-687-1180
TDD/TTY 1-877-941-9231
Fax 1-855-685-6505 (Appeal)
Fax 1-855-678-6982 (Grievance/Complaint)

Member's Name:_____

Member's Ambetter #:_____

Street Address: _____

_____

City State Zip

Member Phone Number:_____

Tracking Number (if applicable. Found in upper left hand corner of denial letter):

_____

Additional information to support the grievance, appeal, concern or recommendation (or attach):

_____

_____

_____

_____

_____

Member or Representative: _____

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.