GRIEVANCE FORM

This form is to help you file a grievance. 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:

Nebraska Total Care
Grievances
2525 N. 117th Ave
Omaha, NE 68164
Fax 1-844-655-0567

PLEASE PRINT

Member's Name: _____

Member's ID#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Member Phone Number: _____

Share information you have about the grievance. If it is related to an authorization request, please provide the authorization or tracking number.

_____

_____

_____

_____

_____

Member signature: _____ **Date:** _____
[SIGNATURE OF MEMBER, PARENT OR GUARDIAN*]

Relationship to member
☐ Self ☐ Parent ☐ Guardian* ☐ Power of Attorney*

*Documents showing Legal Guardianship or Power of Attorney must be provided to Health Plan