Member Grievance and Appeal Form

If you wish to file a grievance or 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:

Ambetter from Sunflower Health Plan
Appeal Department
8325 Lenexa Dr., Suite 200
Lenexa, KS 66214
Phone 1-844-518-9505
TDD/TTY 1-844-546-9713
Fax 1-844-680-5805

Member's Name:_____

Member ID #: _____

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 or appeal (or attach):

_____

_____

_____

_____

Member Signature: _____
**If someone other than the member is requesting the appeal or grievance, please include a signed Authorized Representative Designation Form.*

Daytime Phone #: _____ **Date:** _____
**You must file an appeal within 180 calendar days of the date of the denial letter.*

AMB16-KS-C-00048