



Member Grievance, Appeal, Concern or Recommendation 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
Attn: Appeals and Grievances Department
8325 Lenexa Dr., Suite 410
Lenexa, KS 66214
Phone 1-844-518-9505
TTY 711
Fax 1-844-680-5805**

Member's Name: _____

Member ID #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Member Phone Number: _____

For an Appeal request, provide the Tracking/Authorization Number of your denial:

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.*