# Member Appeals & Grievances (A&G)

## Quick Reference Guide

<table>
<thead>
<tr>
<th>Appeal</th>
<th>A request for the Plan to reconsider a previous decision regarding an adverse determination (denial/adverse action).</th>
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| Initiate | **Medicaid:** Must be filed within 60 days from denial  
**Ambetter:** Must be filed within 180 days from denial  
**Expedited:** Can be requested verbally or in writing  
**Standard:** Must be followed up in writing |
| Necessary information | Who is filing the appeal?  
Who is the appeal for?  
What is being appealed?  
Why are they appealing (i.e., why is the service necessary?)  
*Supporting clinical documentation is usually helpful* |
| Member Consent | **Medicaid:** Member Consent required in writing for anyone appealing on behalf of the member. Appeal is considered received when member consent is received.  
**Ambetter:** Member Consent required in writing for anyone appealing on behalf of the member. Appeal is considered received when member consent is received.  
*Member Consent is not required when the member requests the appeal or when the appeal is Expedited* |
| Resolution timeframe | **Expedited:**  
- 72 Hours (*expedited may be requested but it may not meet the criteria for expedited review)  
- 24 Hours for Non-Formulary Drug Appeals (Ambetter only)  
**Standard:**  
- Medicaid: 30 calendar days from receipt  
- Ambetter: 30 calendar days from receipt (45 calendar days from date of notification if missing info)  
- 72 Hours for Non-Formulary Drug Appeals (Ambetter only) |
| Follow up | All appeals will be acknowledged and resolved in writing. |
| Grievance | An expression of dissatisfaction about any matter other than an "adverse action"†. May also be referred to as a complaint. |
| Initiate | **Medicaid:** Can be submitted verbally or in writing. No filing limit.  
**Ambetter:** Must be in writing and filed within 180 days. |
| Necessary information | Who is filing the grievance?  
*Provider can file a grievance on the member’s behalf with the member’s written consent/signed authorized representative form*  
Who is the grievance regarding?  
What is being complained about?  
Where & When did the incident happen?  
What is the expected resolution? |
| Resolution timeframe | **Medicaid:** 45 calendar days from the date of receipt.  
**Ambetter:** 30 calendar days from the date of receipt.  
*Clinically urgent grievances will be resolved no later than 3 calendar days from receipt* |
| Follow up | All grievances acknowledged & resolved in writing. |

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*Mandatory information for Medicaid and Ambetter:  
- Medicaid A&G Fax: 866-270-9943  
- Ambetter A&G Fax: 877-851-3992  
- Telephone: 866-769-3085, x65003 (Debt VM)*

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†A decision by the Health Plan to deny or limit a requested authorization or service. The Plan’s failure to make a decision within a required timeframe, or the member being unable to access health care services in a timely manner are adverse actions.