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:

SilverSummit Healthplan
Appeal Department
2500 North Buffalo Drive, Suite 250
Las Vegas, NV 89128
Phone 1-866-263-8134
TDD/TTY 1-855-868-4945
Fax 1-855-742-0125 (Grievances & Appeals)

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.

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